Supreme Court, U.S.
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No. 1

In The
Supreme Court of the United States

PAUL J. MEYERS, M.D.,
Petitioner,

v.

RIVERSIDE HOSPITAL, T/A RIVERSIDE REGIONAL MEDICAL CENTER; RUDOLPH FREEMAN, JR., M.D.; RICHARD HOEFER, M.D.; CHARLES FAULK, M.D.; BRUCE KAUDER, M.D.; AND PAUL REIN, M.D.
Respondents.

On Petition for Writ of Certiorari to the Supreme Court of Virginia

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Does the trial court or the jury decide whether a hospital's professional review action met the standards of 42 U.S.C. § 11112(a) and, therefore, whether the hospital is immune under 42 U.S.C. § 11111(a)(1)?

2. On a motion for summary judgment, does the trial court apply a deferential standard to determine whether a physician has produced sufficient evidence to rebut, by a preponderance of the evidence, the presumption of immunity under 42 U.S.C. § 11112(a)?

3. Does 42 U.S.C. § 11113 authorize an award of attorney's fees where a plaintiff's underlying claim is meritorious and plaintiff's challenge to defendant's presumption of immunity involves a case of first impression in the jurisdiction?

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OPINIONS BELOW

The decision of the Virginia Supreme Court, dated October 24, 2007, finding no reversible error in the trial court's decision, is reproduced at App. A, 1a.

The letter opinion of the Circuit Court for the City of Newport News, dated June 12, 2006, denying plaintiff's motion for reconsideration and granting defendants' motion for reconsideration and sustaining their demurrer to plaintiff's *Third Amended Motion for Judgment*, is reproduced at App. B, 3a-5a. The order entered by the court on September 15, 2006 dismissing plaintiff's complaint with prejudice, is reproduced at App. C, 6a-8a. Excerpts from the hearing that contain the trial court's ruling awarding defendants attorney's fees is reproduced at App. D, 11a, and the court's final order, entered on October 31, 2006, is reproduced at App. E, 12a-14a.

The trial court's letter opinion, dated July 27, 2005, holding that plaintiff failed to rebut the presumption of immunity and that defendants were immune under 42 U.S.C. § 11111(a)(1), but overruling the demurrer to the *Third Amended Motion for Judgment*, is reproduced at App. F, 15a-16a. The order entered by the court on August 5, 2005 is reproduced at App. G, 17a-19a.

JURISDICTION

The trial court entered a final order in this case on October 31, 2006. The Virginia Supreme Court refused plaintiff-appellant's Petition for Appeal on October 24, 2007. This petition is timely filed under Supreme

Court Rule 13.1, and this Court has jurisdiction pursuant to 28 U.S.C. § 1257(a) to review the decision of a lower state court that is subject to discretionary review.

Under Virginia law, litigants do not have a right of appeal to an intermediary appellate court from civil cases sounding in tort or contract, *see* Va. Code §§17.1-405 and 406 (defining the appellate jurisdiction of the Virginia Court of Appeals), and must petition the Virginia Supreme Court for appeal, *see* Va. Sup. Ct. R 5:7. Refusal of a Petition for Appeal is a judgment on the merits, *see Saunders v. Reynolds*, 204 S.E. 2d 421, 424 (Va. 1974), although if, as in this case, the court does not write an opinion, the decision has no precedential value, *see Sheets v. Castle*, 559 S.E. 2d 616, 619 (Va. 2002).

STATUTORY PROVISIONS INVOLVED

The relevant statute is the Health Care Quality Improvement Act, 42 U.S.C. §§ 11111(a), 11112(a), and 11113. These are reproduced at App. H, 21a-24a.

STATEMENT OF THE CASE

This case raises the questions of who decides whether a hospital's professional review action met the requirements for immunity under the Health Care Quality Improvement Act, ("HCQIA" or "Act") and whether a deferential standard should be applied to make that determination. These questions have important consequences for the medical profession and the public because how they are decided will affect how peer review is practiced.

Whether immunity under the HCQIA is a question of law to be decided by the trial court, like immunity under 42 U.S.C. § 1983, or a mixed question of fact and law to be decided by the jury, like the standard of medical care, has divided the federal circuits. *See Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1333-34 (11th Cir. 1994), *cert. denied* 514 U.S. 1019 (1995) (immunity a question of law); *Singh v. Blue Cross / Blue Shield of Massachusetts, Inc.*, 308 F.3d 25, 34-35 (1st Cir. 2002) (immunity a mixed question of fact and law). In this case, the trial court treated defendants' immunity as a question of law for the court to decide, and applied an incorrect deferential standard inconsistent with the standard Congress enacted and federal appellate courts and courts of last resort of other States have applied.

I. BACKGROUND ISSUES

Congress enacted the immunity provisions of HCQIA to encourage physicians to engage in effective peer review of their colleagues as a means to improve the quality of medical care and protect patients. 42 U.S.C. § 11101(5), App. H, 21a. Without such protection, Congress believed that

> the threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discouraged physicians from participating in effective professional peer review.

Id. at § 11101(4); App. H, 20a-21a; *Gordon v. Lewiston Hosp.*, 423 F.3d 184, 202 (3d Cir. 2005) ("At its heart,

the HCQIA was intended to deter antitrust suits by disciplined physicians").

For immunity to attach under 42 U.S.C. § 11111(a)(1), professional review actions[1] must meet the due process requirements and reasonableness standards of 42 U.S.C. § 11112(a). *See Brown v. Presbyterian Health Care Services*, 101 F.3d 1324, 1333 (10th Cir. 1996) These standards are objective. *See Singh*, 308 F.3d at 32 ("Our sister circuits have uniformly applied all the sections of § 11112(a) as objective standards). There is a presumption that professional review actions meet these requirements and standards, but the physician may rebut the presumption by a preponderance of the evidence. 42 U.S.C. § 11112(a), App. H, 23a.

These standards seek "to balance the chilling effect of litigation on peer review with concerns for protecting physicians improperly subjected to disciplinary action". *See Bryan*, 33 F.3d at 1322 n.3. Congress cut back the scope and level of immunity in the original bill in response to concerns that the immunity would be misused for discriminatory, anticompetitive and other antisocial reasons. *See* Charity Scott, *Medical Peer Review, Antitrust, and The Effect of Statutory Reform*, 50 Md. L. Rev. 316, 330-332 (1991) (describing amendments to the original bill to limit the scope of immunity). For example, the standard for rebutting the presumption of immunity was reduced from clear and convincing evidence in the

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[1] *See* App. H, 26a-27a, 42 U.S.C. § 11151(9) (defining professional review action).

original bill, *see* H.R.5110, Sec. 102(a), App. I, 30a-31a, to the preponderance of the evidence, *see* 42 U.S.C. § 11112(a), App. H, 23a.

The statutory presumption merely shifts the burden to the physician to prove that a hospital's actions breached the statutory standards. *See* Scott, supra at 348 (explaining that the presumption of immunity, like the 'presumption of innocence', is not a true legal presumption at all). It does not change the burden of production,[2] who decides the question of immunity, or how the evidence should be reviewed on a motion for summary judgment asserting immunity under HCQIA. *Id.* at 381 ("judge must decide, not whether she believes that the defendants more probably than not did not comply with the four immunity standards, but rather whether a rational jury could so find on the evidence presented by the plaintiff"); *Reeves v. Sanderson Plumbing Products*, 530 U.S. 133, 149-51 (2000) (court should credit non-moving party's evidence and only the evidence of the movant that a jury is required to believe) (not a HCQIA case). Never the less, some courts have misunderstood the presumption to create what

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[2] The forum's law of summary judgment is applied. *See Manzetti v. Mercy Hosp. of Pittsburgh*, 776 A.2d 938, 944 (Pa. 2001). In Virginia, summary judgment is disfavored. *Slone v. General Motors Corp.*, 457 S.E.2d 51, 52 (Va.1995) (quoting *Turner v. Lotts*, 457 S.E.2d 765, 766 (Va. 1992). Where conflicting inferences can be drawn from undisputed facts, those favoring the non-moving party must be drawn, and if such inferences would allow the non-moving party to prevail at trial, summary judgment is improper. *See Pugh v. Commonwealth*, 292 S.E.2d 339, 341 (Va. 1982).

amounts to a 'minimal basis' standard that raises the level of immunity, protects abuses of the peer review process, and disturbs the balance Congress deliberately struck by its amendments to the bill.

> I must concur in the result reached in the majority opinion because HCQIA sets such a low threshold for granting immunity to the hospital's so called peer review. Basically, as long as the hospitals provide procedural due process and state some minimal basis related to quality health care, whether legitimate or not, they are immune from liability. Unfortunately, this may leave the hospitals and review board members free to abuse the process for their own purposes without regard to quality medical care.
>
> Unfortunately, the immunity provisions of HCQIA sometimes can be used, not to improve the quality of medical care, but to leave a doctor who is unfairly treated without any viable remedy.

See Meyer v. Sunrise Hosp., 22 P.3d 1142, 1153-54 (Shearing, J., with whom Rose, J., agrees, concurring); *accord* Note: *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. Contemp. Health L. & Pol'y 239, 252-53 (2001) (discussing evidence that peer review is often misused but protected by federal and state immunity statutes).

In this case, the Virginia Supreme Court's decision has eroded the statutory safeguards against misuse of the peer review process still further by treating the question of immunity as one of law for the court to decide, and by substituting the judicially created doctrine of non-review the court adopted in *Khoury v. Community Memorial Hospital, Inc.*, 123 S.E.2d 533 (Va.1962) and *Medical Center Hospital v. Terzis*, 367 S.E.2d 728 (Va. 1988) for the objective reasonableness standard Congress enacted. *See* 42 U.S.C. § 11112(a), App. H, 23a. Under this standard, any action a hospital takes on a physician's privileges will be deemed objectively reasonable so long as the hospital offers the physician a hearing, and abuses of the peer review process protected. *See* App. J, 33a, ¶ 4 ("If due process is afforded through an administrative action that satisfies HCQIA, then that's what you are entitled to and immunity flows from that").

II. BACKGROUND FACTS

Riverside Regional Medical Center, plaintiff's employer, summarily suspended all of plaintiff's clinical privileges on March 1, 2000, and on July 25, 2000, the Medical Executive Committee ("MEC") recommended that all his privileges be revoked. This law suit arises from these actions.[3]

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[3] Riverside recruited plaintiff in 1991 to provide hands-on surgical training to its residents after its residency program in obstetrics and gynecology ("Ob-Gyn") was placed on probation. Because of plaintiff's surgical and teaching skills, the residents selected plaintiff to supervise their most difficult cases, and most of plaintiff's surgical cases were high-risk indigent patient with complex surgical problems. App. K, 36a-39a.

Plaintiff's suspension was based on five intraoperative complications that occurred over a three and a half month period. All involved endoscopic procedures, none resulted in a mortality or permanent injury, and four resulted in no adverse outcomes at all. An added justification for the suspension was that plaintiff's *endoscopic* privileges had been suspended on December 11, 1998 and he had recently completed a proctorship imposed after that suspension.[4] In his report, plaintiff's proctor stated:

> In my opinion, Dr. Meyers is a competent and talented endoscopic surgeon, and is a valuable part of our local medical community. I have never understood why his privileges were restricted, as the apparent result of his having experienced recognized and accepted surgical complications, which were appropriately managed...Indeed, our medical community could profit considerably from Dr. Meyers sharing his skills with his colleagues, something he willingly does.

See App. L, 41a-42a.

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[4] The allegation was also made that plaintiff had asked a nurse to alter the medical records of a patient. The ad hoc committee interviewed the nurse and found no evidence to support this allegation. Never the less, the MEC rejected the ad hoc committee's findings and a letter making the allegation that plaintiff had asked a nurse to alter a patient's medical records was published to another hospital where plaintiff had privileges in gynecology.

During the investigation that led up to the imposition of the proctorship, several documents were generated that contained fabrications, contrived criticisms, and false or misleading statements about plaintiff and his cases. Plaintiff was never provided these documents at the time because Riverside denied plaintiff a hearing on the 1998 suspension notwithstanding that it was imposed for more than 30 days. *See* 42 U.S.C. § 11111(c)(1)(B), App. H, 24a. The ad hoc committee appointed to investigate plaintiff following the 2000 suspension ("ad hoc committee") relied on these documents and accepted them at face value.

The ad hoc committee did not review the medical records of a single case on which the suspension was based or those of any other of plaintiff's patients. It relied exclusively on the report of an external reviewer who did not review two of the five cases on which the suspension was based, and who was provided incomplete medical records on almost all the cases he reviewed. App. M, 44a, ¶ 8 ("I had a lot of things missing in almost every case"). On being apprized of the missing information at his deposition, the reviewer withdrew almost all the criticisms in his report. *Id.*, 45a. The ad hoc committee met with plaintiff but it never discussed the cases on which the suspension was based. The plaintiff was not provided with a copy of the reviewer's report until after he met with the ad hoc committee, and could not raise the inaccuracies in the report himself.

Riverside was, however, on notice that the reviewer's report was flawed. Some members of the ad hoc committee knew that one of the reviewer's main

criticisms was incorrect, yet continued to rely uncritically on the report and accepted it at face value. In addition, the then Chairperson of Obstetrics and Gynecology, Dr. Karen Bruder, after reading the report, informed the Vice President of Medical Affairs, defendant Rudolph Freeman, Jr., M.D., who oversaw the investigation, that there were many problems with the report. She asked Freeman to see the medical records on which the report was based but Freeman denied her request.

In a report to the MEC, the ad hoc committee stated that no objective standards existed for laparoscopic case selection or an acceptable rate of laparoscopic complications. The committee concluded that the plaintiff's judgment regarding endoscopic procedures was questionable, probably overly aggressive and resulted in an increased number of complications, but expressly stated that its conclusions were subjective and based on the reviewer's report and documents the committee had reviewed.[5] The committee expressly stated that it made no conclusions about plaintiff's obstetrical and open (non-laparoscopic) surgical cases, and made no recommendations as to what action, if any, should be taken on plaintiff's laparoscopic privileges.

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[5] One of these documents contained the false statement that plaintiff's laparoscopic complication rate for 1998 was 15%. This figure was arrived at by including in the rate calculation all of plaintiff's complications but only about a third of his laparoscopic cases.

On July 25, 2000, the MEC recommended to the Board of Trustees that all of plaintiff's clinical privileges be revoked without reviewing any medical records, interviewing plaintiff or conducting any other investigation of its own. On June 4, 2001, after a hearing lasting several days, a hearing panel determined that plaintiff's laparoscopic complication rate was, if anything, lower than reported in the medical literature, and recommended reinstatement of all plaintiff's privileges. However, because plaintiff had by that time not operated for over a year, the panel suggested that he be proctored for some cases but the MEC refused to accept this reason for the proctorship and insisted that it be imposed because plaintiff's clinical judgment was impaired.

III. DECISIONS OF THE TRIAL COURT

Defendants first asserted immunity under HCQIA in a demurrer to plaintiff's *Third Amended Motion for Judgment* (*TAMFJ*) alleging multiple counts of defamation per se and tortious interference with advantageous relationships.[6] Relying on *Bryan*, 33

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[6] Retired Judge John E. Clarkson, sitting by designation of the Virginia Supreme Court, sustained defendants' demurrer to the *First Amended Motion for Judgment* on the pleadings. Defendants did not assert immunity under HCQIA at that time. After plaintiff filed a *Second Amended Motion for Judgment*, the case was stayed for over eighteen months due to insolvency of defendants' insurer. After the case was reinstated on the court's active docket, plaintiff amend his complaint by leave of court and dismissed a party and contract based claims.

F.3d at 1331-2, 1337, defendants argued that the question of their immunity was one of law for the court to decide and that, to decide that question, the court should defer to the judgment of the peer reviewers rather than substitute its judgment for theirs. Plaintiff contended that the standard was objective, not deferential, and that the question of immunity was one of fact to be decided by the jury. By leave of court, plaintiff submitted post-hearing briefs on these issues.

The trial court, following Eleventh Circuit precedent, decided that defendants were immune under 42 U.S.C. § 11111(a)(1) and that plaintiff had failed to rebut the presumption of immunity by a preponderance of the evidence. App. F, 16a. Never the less, the court overruled defendant's demurrer to the defamation counts holding that if, as plaintiff had alleged, defendants made false statements with

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In his *Third Amended Motion for Judgment*, plaintiff alleged an unusual amount of factual detail in support of his claims, and attached supporting documents, to evidence that his allegations of fabrication and false statements were not bare assertions, because during the hearing on the demurrer to the *First Amended Motion for Judgment*, the court stated that it had "a hard time believing that a group of doctors were so evil". *See* App. N, 48a, ¶ 3. Further documents were attached by motions craving oyer by both parties. App. G, 18a, ¶ (a). Defendants attached expert reports on which the hospital never relied for the recommendation to revoke all of plaintiff's privileges, and affidavits which plaintiff rebutted by his own third party affidavits.

knowledge of falsity, they would lose all immunity. App. G, 18a, ¶ (b).[7]

Six months later, defendants moved the court to reconsider its ruling based on the holding and reasoning of *Jenkins v. Methodist Hospital of Dallas*, No. 3:02-CV-1823-M, 2004 U.S. Dist. LEXIS 28094 (N.D. Tex. August 18, 2004). Defendants contended that 42 U.S.C. § 11111(a) provides two independent bases of immunity to persons who provide information to a professional review body, and that the court, having found that the hospital was immune under 42 U.S.C. § 11111(a)(1), erred in overruling their demurrer because even if anyone had provided false information with knowledge of falsity, they would still be immune under 42 U.S.C. § 11111(a)(1)(D), even if they lost immunity under 42 U.S.C. § 11111(a)(2).

Before ruling on the motion, the trial court granted plaintiff' leave to file a motion to reconsider the court's original ruling that defendants were immune under 42 U.S.C. § 11111(a)(1), and to submit evidence obtained through discovery since the original ruling on the demurrer. *See* App. J, 34a, ¶ 4 and 35a, ¶ 4. The court denied plaintiff's motion, and sustained defendants' demurrer without further leave to amend. App. C, 8a, ¶ 1.[8] Although the trial court found *Jenkins* "helpful or

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[7] The court dismissed the tortious interference count with prejudice, App. G, 18a, ¶(c), and plaintiff did not appeal that decision.

[8] Under Virginia law, when a trial court considers facts in ruling on a demurrer, thereby treating it as if it were a motion for summary judgment, the Virginia Supreme Court will review the

decisive", App. B, 4a, ¶ 2, it did not sustain defendants' demurrer based on the holding of *Jenkins* but on the factual finding that plaintiff's evidence contained only examples of false statements made with reckless disregard of the truth and not with knowledge of falsity, *id.*, 5a, ¶ 1.The court reaffirmed its earlier ruling that plaintiff failed to rebut the presumption of immunity, and specifically held that defendants had conducted a reasonable investigation. *Id.*, 4a, ¶ 4.

Defendants then moved for attorney's fees pursuant to 42 U.S.C. § 11113. Without making any findings of fact, the court held that plaintiff's law suit was "unreasonable and without foundation brought". App. D, 11a, ¶ 2.

IV. DECISION OF THE VIRGINIA SUPREME COURT

Plaintiff raised the question of whether immunity should be one of law for the court to decide in his reply brief as one subsumed in, and anterior to, the question of whether the court should decide immunity by applying a deferential standard. The defendants raised the question of deference in their brief opposing the petition for appeal by arguing that *Bryan* required federal courts to apply a deferential standard under 42 U.S.C. § 11112(a), consistent with the standards adopted by the Virginia Supreme Court in *Khoury*, 123 S.E.2d at 539 & *Terzis*, 367 S.E.2d at 730. Plaintiff

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trial court's ruling under a summary judgment standard so long as the non-moving party - i.e. the plaintiff in this case - fails to object. *See Shelton Motor Co. v. Miller*, 544 S.E.2d 345, 348 (2001).

contended that defendants misconstrued *Bryan*'s *dictum*. By finding no reversible error in the judgment, App. A, 1a, the Virginia Supreme Court adopted this deferential standard and treated the question of immunity as one of law to be decided by the trial court.

REASON FOR GRANTING PETITION

I. THE FEDERAL CIRCUITS ARE SPLIT OVER WHETHER THE COURT OR JURY SHOULD DECIDE THE QUESTION OF IMMUNITY.

Since "questions of law do not turn upon the satisfaction of evidentiary burdens", whether the standards of section 11112(a) have been met should be a question of fact for the jury to decide. *See Reyes v. Wilson Mem. Hosp.*, 102 F.Supp.2d 798, 810 (S.D. Ohio 1998). And since a hospital's immunity under 42 U.S.C. § 11111(a)(1) depends solely on whether its action(s) met the objective standards of section 11112(a), whether the standards of section 11112(a) have been met and whether a hospital is immune are the same questions framed in different ways.

The Ninth Circuit correctly framed the question to be decided on a motion for summary judgment asserting immunity under 42 U.S.C. § 11111(a)(1) as "Might a reasonable jury, viewing facts in the best light for [the plaintiff], conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of § 11112(a)", and focused the court's inquiry on the sufficiency of the *physician*'s evidence to overcome the statutory presumption. *See Austin v. McNamara*, 979 F.2d 728,

734 (9th Cir. 1992). Although *Bryan* adopted the Ninth Circuit's formulation of the question to be decided on a motion for summary judgment and its focus on the sufficiency of the *physician's* evidence, the court treated the question of immunity as one of law to be decided by the court, analogous to the qualified immunity under 42 U.S.C. § 1983. *See Bryan*, 33 F.3d at 1333-34. Under Eleventh Circuit law, juries are permitted to decide only "subsidiary questions of fact", not the question of immunity. *Id.* The analysis required by *Bryan* created some confusion among the lower courts. *See Reyes*, 102 F.Supp.2d at 810 ("In permitting the issue of HCQIA immunity to be resolved on summary judgment...courts have not always been careful in their explanation of the analysis involved).

The First Circuit has rejected the Eleventh Circuit's analogy between the qualified immunities created by 42 U.S.C. § 11111(a)(1) and § 1983, and the court's holding that the role of the jury in the determination of a hospital's immunity under 42 U.S.C. § 11111(a) "is limited to disputes over subsidiary issues". *Singh*, 308 F.3d at 34. Relying on this Court's functional approach in *Miller v. Fenton*, 474 U.S. 104, 114 (1985), the First Circuit treats the question of whether the physician rebutted the presumption of immunity as a mixed question of fact and law to be decided by a jury, aided, if necessary, by expert testimony as to what reasonable standards of peer review require. *See Singh*, 308 F.3d at 34-35; *accord Brown*, 101 F.3d at 1334 n. 9 (allowing expert to testify that the hospital's investigation was "unreasonably narrow and did not provide a reasonable basis for concluding that the physician

posed a threat to patient safety"). Under First Circuit law, a trial court is permitted to grant summary judgment only "if the evidence of reasonableness within the meaning of the HCQIA is so one-sided that no reasonable jury could find that the defendant health care entity failed to meet the HCQIA standards". *Id.* at 36. If "questions exist regarding the reasonableness of a peer review action", the question is submitted to the jury to decide. *Id.* at 35. The Tenth Circuit's decision in *Brown* is consistent with First Circuit law.

In this case, the trial court recognized that whether the court or the jury should decide the question of defendants' immunity was at issue, and that who decides the question could be outcome determinative. *See* App. O, 51a, ¶ 5 ("I'm worried about who makes the decision...You know, quite frankly, if I was to make it, I think they did everything reasonably....but I am not sure I make that decision"). After considering post-hearing memoranda, the court decided the question of immunity itself. In its letter opinion of July 27, 2005, the court stated,

> I find from the exhibits and arguments of counsel that the standards for professional review actions have been fulfilled. The standards necessary for protection have not been rebutted by a preponderance of the evidence.

App. F, at 16a, ¶ 2. In its letter opinion of June 12, 2006, the court stated,

> I have previously found, and again today find...that the process and standards for professional review of the defendant Hospital under the Health Care Quality Improvement Act ("HCQIA")...were reasonable...

App. B, 4a, ¶ 3.

> I further find that defendants made a reasonable attempt to obtain the facts, the investigation was reasonable and that plaintiff did not rebut defendants' presumption of immunity under 42 VSCS (sic) § 1112(a) (sic) by a preponderance of the evidence.

Id. ¶ 4. By finding no reversible error in the trial court's ruling, the Virginia Supreme Court affirmed that the question of immunity under 42 U.S.C. § 11111(a)(1) should be treated as one of law for the trial court to decide. App. A, 1a.

The reasonableness of peer review should not be decided as a matter of law because it is context dependent, and standards of peer review, like medical standards, can be expected to change with time. As this Court has noted,

> individual pieces of evidence, insufficient in themselves to prove a point, may in cumulation prove it. The sum of an evidentiary presentation may well be greater than its constituent parts.

Bourjaily v. United States, 483 U.S. 171, 179-80 (1987). If immunity is treated as a question of law, the evidence rejected as insufficient to rebut the

presumption of immunity in a particular case will tend to create precedent barring the use of the same genre of evidence notwithstanding that in a different context the probative force of the same evidence may be different or, when combined with other pieces of evidence, may render the evidence as a whole sufficient to rebut the presumption of immunity by a preponderance of the evidence.

II. THE REASONABLENESS STANDARDS OF 42 U.S.C. § 11112(a) ARE NOT DEFERENTIAL.

The defendants urged the courts to apply a deferential standard under 42 U.S.C. § 11112(a), and, relying on *Bryan*, 33 F.3d at 1337, argued that HCQIA prohibited the courts from substituting their judgments for those of the hospital and its peer reviewers. *See* App. J, 33a, ¶ 4 ("If Your Honor gets into examining the facts again, Your Honor is doing exactly what Congress and the courts uniformly have said, and that is we're not here to substitute our judgment for that of the hospital body...Your Honor said...I'm not going to second guess the doctors"). In their briefs supporting the demurrer and opposing the petition for appeal, the defendants asserted:

> Under the Act, the Court's role 'is not to substitute [its] judgment for that of the hospital's governing board or to reweigh the evidence regarding the renewal or termination of medical staff privileges'. *Id.* at 1337 (citation omitted).

> The federal courts' reluctance to inject themselves into hospital's affairs echoes the Virginia Supreme Court's deference to persons charged with the task of governing those institutions. *See Khoury v. Community Memorial Hospital, Inc.*, 203 Va. 236, 245, 123 S.E.2d 533, 539 (Va. 1962) ('[W]hen the trustees of a private hospital, in their sound discretion, exclude a doctor from the use of the facilities of the hospital, the courts are without authority to nullify that discretion by injunctive process'); *see also Medical Center Hospital v. Terzis*, 235 Va. 443, 446-47, 367 S.E.2d 728 (Va. 1988) (*Khoury* articulates a rule of non-intervention in a hospital's internal affairs).

This argument misconstrues the nature of the deference referred to in *Bryan*, 33 F.3d at 1331, and the inquiry required by 42 U.S.C. § 11112(a) to determine if the presumption of immunity has been rebutted by a preponderance of the evidence.

The language the defendants quoted from *Bryan* was taken from *dictum* in *Mahmoodian v. United Hosp. Ctr., Inc.*, 404 S.E.2d 750, 756 (W.Va 1991), *cert. denied*, 502 U.S. 863 (1991),[9] *see Bryan*, 33 F.3d at 1337, and referred to a prudential doctrine of non-review that is "not grounded in statutory or constitutional provisions", *see Feyz v. Mercy Mem. Hosp.*, 719 N.W.2d 1, 8 (Mich. 2006), but was

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[9] In *Mahmoodian*, plaintiff was seeking an injunction to enjoin the hospital from revoking his privileges, and the case was not decided based on HCQIA immunity.

developed by State courts in response to attempts by aggrieved physicians to reverse adverse decisions on their hospital privileges through injunctive relief, *see Sandler v. Dimensions Healthcare Corp.*, 836 A.2d 655, 662-67 (Md. 2003) (reviewing case law on the non-review doctrine).[10] Several jurisdictions have modified the doctrine, *id.* at 664, and the Michigan Supreme Court has abandoned the doctrine altogether, *see Feyz*, 719 N.W.2d at 16-17. After the Virginia Supreme Court adopted the doctrine in *Khoury*, 123 S.E.2d at 539, the Virginia General Assembly modified *Khoury* by requiring hospitals to state their reasons in writing for refusing or later revoking staff privileges. *See* Va. Code § 32.1-134.1 (2006). However, the Virginia Supreme Court interpreted the statute narrowly and held that it "unambiguously limited the court's review to the question of whether the 'reason or reasons stated' are within the statutory criteria...[and did not] authorize a judicial review of either the merits of the hospital's complaint or the procedures the hospital employed in reaching its conclusion". *See Terzis*, 367 S.E.2d at 730.

The standard of review adopted in *Khoury* as modified by *Terzis* is inconsistent with the objective reasonableness standards of 42 U.S.C. § 11112(a). The

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[10] These equitable actions were disfavored, initially on the basis of the business judgment rule, *Sandler*, 836 A.2d at 663; *Natale v. Sisters of Mercy of Council Bluffs*, 52 N.W.2d 701, 709 (Iowa 1952); *Khoury*, 123 S.E.2d at 539 (holding that doctor had no constitutional or statutory rights which would authorize a court to nullify a hospital's decision denying the doctor privileges at the hospital) and later on policy grounds, *see Owens v. New Britain Gen. Hosp.*, 643 A.2d 233, 241 (Conn. 1994) (citing cases).

non-review doctrine is not applicable to common law causes of actions, *see Cooper v. Delaware Valley Med. Ctr.*, 654 A.2d 547, 552 (Pa. 1995) (distinguishing cases seeking injunctions and damages under tort and contract theories), and was never intended to immunize hospital administrators or members of a hospital's medical staff from liability for tortious conduct, *see Natale*, 52 N.W.2d at 709 (acts or omissions of a hospital's board of trustees that wrongfully injured another would incur liability); *Clark v. Columbia / HCA Info. Servs.*, 25 P.3d 215, 220 (Nev. 2001) ("the tangential involvement of the peer review process does not foreclose judicial intervention in the types of disputes normally dealt with in the courts"). Nor does HCQIA authorize deference to governing bodies or peer reviewers in deciding whether a hospital's actions breached the reasonableness standards of 42 U.S.C. § 11112(a). *See* Scott, supra at 403. On the contrary, by amending H.R. 5110 to ensure that an objective standard of reasonableness is applied and subjective good faith of the reviewers would not be deemed sufficient for immunity under HCQIA to attach, Congress effectively rejected a deferential standard of review under section 11112(a). *See Austin*, 979 F.2d at 734; App. I, 30a, Sec. 102(a)(1); 42 U.S.C. § 11112(a)(1), App. H, 23a. Deference is implicit in the good faith standard Congress expressly rejected because under that standard peer reviewers acting in good faith are immunized for any actions they deem appropriate regardless of their objective reasonableness.

Nor can *Bryan* be read to require trial courts to substitute this prudential doctrine for the statutory standards Congress enacted. *Bryan* stands only for the

proposition that once a court determines that plaintiff's evidence is insufficient to rebut the presumption of immunity, HCQIA does not authorize the court to determine what particular disciplinary action the hospital should take. *Bryan*, 33 F.3d at 1337 (physician did not challenge events that prompted termination of privileges, only contended that they did not warrant such severe punishment); *accord N. Colo. Med. Ctr. v. Nicholas*, 27 P.3d 828, 840 (Colo. 2001) (stating, "[w]here the requirements of section 11112(a) are fulfilled, we need not extend our inquiry further"); *Meyer v. Sunrise Hosp.*, 22 P.3d 1142, 1151 (Nev. 2001) ("issue is not whether...a judge or jury believes that the penalty was too harsh").

In as much as HCQIA does not apply to injunctions, *see Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1031 (4th Cir. 1994), it is true that the intent of HCQIA was not to replace the judicially created non-review doctrine. However, a judicially created doctrine cannot replace or modify the standards in a federal statute, and, hence, support a deferential standard of review under 42 U.S.C. § 11112(a).

It is also true that HCQIA does not preempt state law that affords additional or greater protection to peer reviewers, *see* 42 U.S.C. § 11115(a); App. H, 25a, and, therefore, nothing in HCQIA prevents States from enacting statutes that provide immunity based on a deferential standard if they wish to do so. Virginia has done just that by enacting legislation that immunizes peer reviewers for any good faith actions and that requires clear and convincing evidence to prove bad faith. *See* Va. Code § 8.01-581.16. But this is precisely the standard in H.R. 5110 that Congress expressly

rejected when it enacted 42 U.S.C. § 11112(a). *See* App. I, 30a, Sec. 102(a). Therefore, what defendants seek - immunity from objectively unreasonable actions on plaintiff's privileges - is available to them if they acted in good faith, but they must seek it under Virginia law, not by having the courts of Virginia rewrite federal law to protect them.

A. The application of a deferential standard resulted in rulings that conflict with the decisions of federal appellate courts and the courts of last resort of other states.

The incorrect standard urged by defendants was applied by the trial court and resulted in rulings that conflict with the decisions of federal appellate courts and the courts of last resort of other States in several respects. For example, the MEC was required to conduct a reasonable investigation before recommending revocation of all of plaintiff's privileges for immunity to attach to that action. *Singh*, 308 F.3d at 39 (citing 42 U.S.C. § 11112(a)(2). Whatever else a reasonable investigation may require, all courts agree that it requires review of the medical records of the cases on which a summary suspension of privileges was based. *Singh*, 308 F.3d at 42; *Imperial*, 37 F.3d at 1029; *Manzetti*, 776 A.2d at 943. The trial court ruled otherwise in this case because under the deferential standard it applied everything peer reviewers do is deemed reasonable.

In *Singh*, 308 F.3d at 42, the First Circuit rejected the contention that defendants had not conducted an adequate investigation precisely because members of

the Remedial Action Committee, who investigated plaintiff, independently reviewed several of the medical records on which the external reviewer's report was based, and did not simply rely on the external reviewer's report. In *Imperial*, 37 F.3d at 1029, the Fourth Circuit emphasized that the Credentials and Executive Committees had independently reviewed the plaintiff's competence, and each committee had independently determined that plaintiff should not be reappointed. Both these committee reviewed the medical records of several of plaintiff's cases to make their determination about reappointment. *See Imperial v. Suburban Hosp. Ass'n, Inc.*, 862 F.Supp. 1390, 1393-94 (D.Md. 1993).

In *Manzetti*, 776 A.2d at 943, the Supreme Court of Pennsylvania rejected plaintiff's specific challenge to the adequacy of the hospital's investigation by noting that after the Medical Executive Committee summarily suspended plaintiff's privileges to perform open heart surgeries, it decided to conduct further investigation into the matter and reconvene three weeks later. During this investigation the MEC "examined the medical records of more than a score of [plaintiff's] open-heart cases...[and] conducted interviews with eight anesthesiologists who had worked with Manzetti during open-heart surgeries".

In the only decided case that is at all analogous to the present one, the committees investigating a physician's practice did not review the medical records of his patients but relied on summaries contained in the report of an external reviewer, as in this case. *See Clermont v. Fallon Clinic*, No. 2001-1512B, 1998 Mass. Super. LEXIS 738 at *20-24 (Mass. Super. Ct. May 15,

2003). The Superior Court of Massachusetts, relying on the First Circuit's decision in *Singh* and the district court's decision in *Imperial*, held that a reasonable jury could conclude that the investigation preceding the peer review actions was obviously insufficient and, therefore, unreasonable. *Id.*[11]

In this case, the ad hoc committee relied on information provided to it by others, accepted the information at face value, and much of what the committee relied on was factually incorrect, fabricated or contrived.[12] Finding an investigation reasonable where reliance was placed on documents that contained numerous fabrications, false statements and contrived incidents is also inconsistent with the position of other appellate courts that "fabricating damaging incidents or purposeful overreacting would be conduct that no reasonable medical practitioner or

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[11] In this case, the investigation was even less reasonable than in *Clermont* in that the medical records sent to the external reviewer were incomplete. App. M, 44a, ¶ 8.

[12] For example, the "recent" laparoscopic complication used to justify plaintiff's suspension at Riverside occurred at the surgery center (a different legal entity at the time), and plaintiff's management of the case had already been determined to have been appropriate. *See* App. P, 52a, ¶ 2-53a, ¶ 1; *see also id.*, 54a, ¶ 1 (cases used to justify suspension changed during the investigation); *id.*, 53a, ¶ 3 (after the fact entries made in the medical records by nurses). One of the two cases used to justify imposing a proctorship of plaintiff's laparoscopic cases was treated seven months earlier and was determined to have been appropriately managed in the ordinary course of peer review. Criticisms were then fabricated about this case.

hospital could believe to be part of legitimate peer review". *See Boczar v. Manatee Hosp. & Health Sys. Inc.*, 993 F.2d 1514, 1518 (11th Cir. 1993); *accord Meyer*, 22 P.3d at 1151 ("There is no evidence or allegation that the doctors who evaluated Meyer's performance... were *manufacturing* or *exaggerating* facts to support disciplinary sanctions").

Even accepting, *arguendo*, that some corrective action on plaintiff's laparoscopic privileges was warranted, the holding that it was reasonable to suspend, and to recommend revoking, all of plaintiff's clinical privileges conflicts with decisions of federal circuit courts and other state courts of last resort holding that the action must be tailored to the concerns raised. In *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 638 (3d Cir. 1996), the hospital suspended the privileges of an orthopedic surgeon to perform spine surgery, and the court concluded that

> Because these restrictions were tailored to address the health care concerns raised...we believe the evidence supports the conclusion that the restrictions were imposed based on a reasonable belief that they were warranted by the facts known".

Id.; *accord Manzetti*, 776 A.2d at 943 (plaintiff, a cardiac surgeon with privileges "to perform all types of open heart and vascular surgical procedures", had his cardiac surgical privileges suspended after concerns were raised about his cardiac surgical skills and experience, but not his vascular surgical privileges).

In this case, the criticisms of plaintiff were confined to his endoscopic surgical practice, and laparoscopic cases in particular. The suspension in 1998 involved endoscopic cases and only laparoscopic cases were proctored. The cases that triggered the 2000 suspension all involved endoscopic procedures. The ad hoc committee that investigated the 2000 suspension expressly stated in its report that it drew no conclusions about plaintiff's obstetrical and non-laparoscopic surgical practice. Never the less, the hospital summarily suspended all of plaintiff's clinical privileges and the MEC later recommended that they all be revoked without any factual basis that suspension or revocation of plaintiff's obstetrical or non-endoscopic surgical privileges would further health care and protect patients. *See Mahmoodian*, 404 S.E.2d at 761 ("the potential effect on patient care may not be presumed but must be shown by the evidence").

III. THE STATE COURTS APPLIED AN INCORRECT STANDARD UNDER 42 U.S.C. § 11113 AND THEIR AWARD OF ATTORNEY'S FEES CONFLICTS WITH DECISION OF FEDERAL APPELLATE COURTS AND THIS COURT'S PRECEDENT.

The cost shifting provision of 42 U.S.C. § 11113 was drafted in language taken directly from the National Cooperative Research Act of 1984, 15 U.S.C. § 4303. *See* 132 Cong. Rec. H 11591 (daily ed. October 17, 1986) (statements of Rep. Waxman). That language was in turn based on the cost shifting provision of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-

5(k). *See* Scott, supra at 338-39 (1991). Therefore, an award of attorneys fees under 42 U.S.C. § 11113 is reviewed "in the same manner as [the court] review[s] the award of attorney fees under Title VII and 42 U.S.C . § 1988". *Muzquiz v. Foote Memorial Hosp.*, 70 F.3d 422, 431-32 (6th Cir. 1995). In the context of a claim for attorney's fees under Title VII, this Court has said that an award of attorney's fees is not appropriate where the defendant prevails on a case of first impression requiring judicial resolution. *See Christiansburg Garment Co. v. EEOC,* 434 U.S. 412, 423-24 (1978); *accord Sugarbaker v. SSM Health Care*, 187 F.3d 853, 857-58 (8th Cir. 1999) (hospital not entitled to attorney's fees, because no eighth circuit precedent addressed the standards for HCQIA immunity).

Before awarding attorney's fees to a prevailing defendant, the trial court must make factual findings that support a conclusion that the plaintiff's claim(s) or the conduct of the litigation were frivolous, unreasonable, without foundation or in bad faith, 42 U.S.C. § 11113; *Canady v. Providence Hosp.*, 1997 U.S. App. LEXIS 34885 (D.C. Cir. 1997), and the record must actually support such a conclusion, *Imperial v. Suburban Hosp. Ass'n*, 1998 U.S. App. LEXIS 893 at *3-6 (4th Cir. January 22, 1998) (unpublished opinion). In making factual findings to determine if plaintiff's claim was reasonable, this Court has admonished trial courts to resist the temptation to engage in *post hoc* reasoning and hindsight logic that would deter all but the most airtight claims. *See Christiansburg Garment Co.,* 434 U.S. at 421-22; *accord Mathews*, 87 F.3d 624 (important to avoid hindsight logic and conclude that because "plaintiff did not ultimately prevail, his action

must have been unreasonable or without foundation") (citing *Muzquiz*, 70 F.3d at 432).

In this case, the trial court held that plaintiff's claim was "unreasonable and without foundation brought" but made no factual findings to explain its rulings. *See* App. D, 11a, ¶ 2. What factual findings the court did make, do not support an award of attorney's fees because those findings - that false statements were made with reckless disregard of the truth - indicated that plaintiff's underlying claim for defamation was meritorious. *See Food Lion, Inc. v. Melton*, 458 S.E.2d 580, 584 (Va. 1995) (describing elements private plaintiff's must to prove to prevail on a claim for defamation). Moreover, defendants first asserted HCQIA immunity in their demurrer to the *Third Amended Motion for Judgment*, and the court overruled their demurrer to the defamation claim. It cannot be seriously contended that plaintiff should have dismissed his claim for defamation after the court overruled the demurrer to that claim.

There is no Virginia precedent involving HCQIA immunity and this Court has never considered the issue. There is no precedent from any jurisdiction holding peer review actions reasonable under 42 U.S.C. § 11112(a) where these were based on falsehoods and the court actually found that the record contained false statements made with reckless disregard. Nor is there any precedent for holding an investigation reasonable where the committee investigating a suspension failed to review the medical records of the cases on which the action was based. Therefore, plaintiff's challenge to defendants' immunity under 42 U.S.C. § 11111(a)(1) was one of

first impression for Virginia, and his position that defendants are not immune under 42 U.S.C. § 11111(a)(1) was based on facts in the record and case law from other jurisdictions.

The award of attorney's fees by the state courts in this case conflicts with the decision of every federal appellate court that has addressed the issue, and this Court's decision in *Christiansburg Garment Co.* It has given section 11113 an *in terrorem* effect inconsistent with the plain language of the statute and its legislative history. *See* App. I, 31a, Sec. 103 (the original fee shifting provision in H.R. 5110, rejected by Congress, allowed an award of attorney's fees to a prevailing defendant without any further showing). It will further shield improper peer review by discouraging legal challenges to unwarranted peer reviews actions.

IV. THE QUESTIONS PRESENTED ARE IMPORTANT.

Few matters are of greater concern to the general public and the medical profession, or affect them more directly, than the quality of medical care and its oversight. The adoption of legal standards that protect unwarranted peer review actions can be expected to have consequences that are inimical to high quality of care and defeat the very purpose for which HCQIA was enacted, as well destroy the careers of competent, conscientious physicians. *See Boczar*, 993 F.2d at 1518 n.10 (negative peer review actions can ruin a doctor's professional reputation and career).

First, it can be expected to encourage and entrench a discredited approach to peer review that seeks culprits to 'blame and shame' for adverse outcomes and errors rather than causes to remedy and barriers to erect to protects patients. *See e.g.* James Reason, *Human Error*, 320 BMJ 768 (2000), App. Q, 58a, ¶ 2 (stating that "continued adherence to the [persons approach] is likely to thwart the development of safer healthcare institutions").[13] The 'blame and shame' approach does not work because it fails to identify and correct latent failures in the health care environment that increase the uncertainty inherent in medical decisions and predispose to error. *Id.*, 59a, ¶ 1; Ownby at 18.

For example, the hysteroscopic complication at Riverside's surgery center that led to plaintiff's suspension in 1998 was related to fluid overload, and was preceded by two cases of fluid overload in the patients of other physicians. *See* App. P, 53a, ¶ 2. These prior cases were not reviewed, and the latent failures that led to these complications were not identified and corrected. *Id.* (stating that nurse felt procedures should not be done at surgery center). The committees investigating plaintiff also did not identify these deficiencies and were content to blame plaintiff. The deficiencies were eventually corrected only

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[13] *See also* Raymond L Ownby, *Medical Error Prevention*, at 12-14, available at http://www.med.miami.edu/med/education/cme/documents/OwnbyMedicalErrors_SelfInstructional2003_2.pdf (or by searching Google with the search term 'Ownby - medical error prevention')

because the hospital's own external reviewer identified them and urged their correction.[14]

Second, because physicians "who do procedures that are new or different" are often the target of pretextual peer review, *see* Note, 18 J. Contemp. Health L. & Pol'y at 252 (citation omitted), unwarranted peer review actions tend to chill legitimate minority opinions and deprive communities of expertise that would not otherwise be available locally. In this case, plaintiff engendered criticism because he was able to perform laparoscopic and other complex procedures his colleagues could not or would not do. Removing him from the medical staff removed an important resource for the local community. *See* App. R, 67a ("I was very happy that a local surgeon was willing to take on this very complex lady and certainly happy with your fine care"); App S, 69a (testimony of faculty member before hearing panel stating that the local community had "definitely lost an asset"). It also deprived other attendings and the residents of a valuable teaching resource. *See* App. T, 70a, ¶ 2 (attending physician stating that she had improved her proficiency in laparoscopic surgery and understanding of pelvic anatomy by having plaintiff assist her with difficult cases); *see also id.*, 71, ¶ 3 and

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[14] The latent failures were lack of fluid balance protocols and forms on which to record fluid balance, lack of closed-circuit system to measure fluid balance accurately, lack of equipment to measure electrolytes on the premises. A sentinel events inquiry ostensibly conducted by administration also failed to detect these systemic failures.

App. K, 36a-37a (describing plaintiff's influence on the surgical training of residents).[15]

No system of peer review can be error free. Congress has chosen to provide federal protection to peer review that meets certain criteria to encourage effective peer review. *See* 42 U.S.C. § 11112(a); App. H, 23a. Those criteria implicitly strike a balance between erroneously disciplining physicians who should not have been disciplined (false positive or type II error) and erroneously failing to discipline physicians who should have been disciplined (false negative or type I error). Reasonable people may differ over how false positive and false negative errors in peer review should be balanced, except that no reasonable person can believe that fabrications and contrived criticisms will further health care. *See Boczar*, 993 F.2d at 1518. It is also for Congress, not the courts, to determine where the balance should lie.

Congress enacted standards of objective reasonableness and required proof by the preponderance of the evidence to rebut the presumption that a particular professional review action met these standards. *See* 42 U.S.C. § 11112(a); App. H, 23a. The Virginia Supreme Court has changed that balance by adopting a deferential standard that has no parameters, that is an alloy of state and federal law, and that immunizes actions based on falsehoods made with at least reckless disregard of falsity. Only

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[15] Subsequent to these events the entire teaching faculty left and Riverside's Ob-Gyn residency program has been placed back on probation.

this Court can overrule the standard the Virginia Supreme Court has adopted. It should, respectfully, do so because the standard adopted can be expected to undermine the purposes of the statute, protect abuses of peer review, and cause injustice to physicians without any offsetting benefits to the public.

CONCLUSION

For all the foregoing reasons, petitioner, Paul J. Meyers, M.D., respectfully asks this Court to issue a Writ of Certiorari to the Supreme Court of Virginia.

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APPENDIX

APPENDIX A

SUPREME COURT OF VIRGINIA

Record No. 070241
Circuit Court No. CL31394-EH

[Filed October 24, 2007]

Paul J. Meyers, M.D.,	)
Appellant,	)
	)
against	)
	)
Riverside Hospital, Inc., et al.,	)
Appellees.	)
	)

From the Circuit Court of the City of Newport News

Upon review of the record in this case and consideration of the argument submitted in support of and in opposition to the granting of an appeal, the Court is of opinion there is no reversible error in the judgment complained of. Accordingly, the Court refuses the petition for appeal.

Justice Lemons took no part in the consideration of this case.

A Copy,

Teste:

Patricia L. Harrington, Clerk

By: /s/
Deputy Clerk

APPENDIX B

JOHN E. CLARKSON
Retired Judge
FOURTH JUDICIAL CIRCUIT
909 Hanover Avenue
Norfolk, VA 23508

June 12, 2006

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RE: Myers v. Riverside Hospital, Inc., et al
Law No. 31394-EH

Gentleman:

I thank each of you for your most professional handling of this most important case.

In this law action first filed October 23, 2001, of *Paul J. Myers, M.D. v. Riverside Hospital, Inc., et al* alleging damages, I have reviewed the many briefs filed, the cases cited and the 100 exhibits filed with plaintiff's Motion for Reconsideration. I find, through able counsel, cases that are either helpful or decisive on the issues presented here. *Jenkins v. Meth. Hospital Dallas, Singh, M.D. v. Blue Cross and Blus Shield and Rose Fuste, M.D.* and *Tien L. Vanden Hoek, M.D. v. Riverside Healthcare Association, Inc.*, 29743-VC, Circuit Court for the City of Newport News, VA.

I have previously found, and again today find, from the pleadings, exhibits, briefs, records of other cases, and after reviewing plaintiff's Motion for Reconsideration, his brief supporting the Motion for Reconsideration with the attached 100 exhibits, that the process and standards for professional review of the defendant Hospital under the Health Care Quality Improvement Act ("HCQIA"), 42 VSC §11101, were reasonable and, therefore, under (a)(1) those that participated in or assisted with the peer review activity are immune from damages.

I further find that defendants made a reasonable effort to obtain the facts, the investigation was reasonable and that plaintiff did not rebut defendants' presumption of immunity under 42 VSCS § 1112(a) by a preponderance of the evidence. Further, I find no evidence from the pleadings, exhibits, or argument of

counsel, that any one providing information to the medical review body provided false information proving that such information was false. Much information received by the review body has been alleged as false by plaintiff, but I find no evidence that the person *knew* it was false or testified untruthfully. I find no evidence or allegation of where, when or relevance of any alleged to be false evidence *knowingly* given, only examples of "reckless disregard" or a difference of opinion as to very complicated medical procedures. Experts do disagree.

Plaintiff's Motion for Partial Summary Judgment, with Motion for Sanctions, is denied.

Plaintiff's Motion for Reconsideration is denied.

Defendant's Demurrer to the Plaintiff's Third Amended Motion for Judgment is sustained, with no further leave to amend, dismissing this action with prejudice.

I ask Mr. Harris to prepare a sketch of an order, noting any objections, and after proper endorsement by all counsel, send to the Court for entry. The only issue remaining is defendants' Motion under § 11113 for payment of reasonable attorneys' fees and costs in defense of suit. This may be briefed and/or set for further hearing at a date convenient to Court and counsel.

Respectfully,
/s/
John E. Clarkson
Judge Designate

APPENDIX C

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394EH

[Filed September 15, 2006]

PAUL J. MEYERS, M.D., Plaintiff,	)
v.	)
RIVERSIDE HOSPITAL, INC., *et al.*, Defendants.	)

ORDER

On April 20, 2006, the parties, by counsel, appeared before this Court to present oral argument on the following motions:

- Defendants' Motion for Reconsideration of Demurrer;
- Plaintiff's Motion for Partial Summary Judgment;
- Defendants' Motion for Sanctions;

- Defendants' Motions for Protective Order; and

- Plaintiff's Motions to Compel.

At the hearing, the Court denied Plaintiff's Motion for Partial Summary Judgment and Defendants' Motion for Sanction on the same. The Court granted the Plaintiff's oral motion to file a written motion to reconsider the ruling on the Demurrer reflected in the Order entered on August 16, 2005, holding that the Defendants' actions complied with the statutory standards under the Health Care Quality Improvement Act and that the Plaintiff had failed to rebut the Defendants' presumption of immunity by a preponderance of the evidence but overruling the Demurrer, holding that the Plaintiff had alleged that the Defendants had knowingly made false statements, and if that was true, they lost all immunity. The Court Ordered the Plaintiff to submit a brief within 30 days and the Defendants to submit an answer within 30 days of the Plaintiff's brief. Because the Defendants' Motion for Reconsideration could dispose of discovery, the Court held in abeyance the parties' respective Motions relating to discovery. The Court took the Defendants' Motion for Reconsideration under advisement.

After considering the briefs and arguments of counsel, the Court grants the Defendants' Motion for the reasons stated in the Court's letter Opinion dated June 12, 2006, which is incorporated by reference into this Order. After considering the brief submitted by the Plaintiff, the Court denies the Plaintiff's Motion for

Reconsideration of the Court's ORDER on August 16, 2005. The Court sustains the Demurrer and denies the Plaintiff any further leave to amend.

This action shall remain on the active docket for consideration of an award of reasonable attorney's fees and costs to the Defendants pursuant to 42 U.S.C. § 11113.

The Court directs the Clerk of Court to send a *teste* copy of this Order to counsel of record.

ENTER: Sept./ 15 / 2006

/s/
Judge John E. Clarkson, Judge Designate

Seen and agreed to regarding the Court's (1) granting the Defendants' Motion for Reconsideration, (2) sustaining the Demurrer, (3) denying Plaintiff's Motion for Reconsideration, and (4) denying Plaintiff's Motion for Partial Summary Judgment, but objecting to the Court's denying the Defendants' Motion for Sanctions:

/s/
Robert L. Harris, Jr., Esquire (VSB 33454)
LeClair Ryan, A Professional Corporation
The Federal Reserve Bank Building
701 East Byrd Street, 16th Floor
Post Office Box 2499
Richmond, Virginia 23218-2499

Telephone: (804) 545-1505
Facsimile: (804) 545-1501

Counsel for the Defendants

Seen and objected to:

/s/_____
Terrence K. Martin, Esquire (VSB 06845)
714 J. Clyde Morris Boulevard
Newport News, Virginia 23607
Telephone: (757) 599-9822
Facsimile: (757) 599-9824

Nicholas Kadar, M.D., J.D., LLM
11 Jackson Court
Cranbury, New Jersey 08512
Telephone: (609) 655-2459
Facsimile: (609) 395-9514

Counsel for the Plaintiff

APPENDIX D

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394-EH

[September 15, 2006]

PAUL J. MEYERS, M.D.,
Plaintiff,

v.

RIVERSIDE HOSPITAL, INC., t/a RIVERSIDE REGIONAL MEDICAL CENTER, *et al.*,
Defendants.

BEFORE: The Honorable John E. Clarkson, Judge

DATE: September 15, 2006

APPEARANCES: NICHOLAS KADAR, ESQ.
11 Jackson Court
Cranbury, New Jersey 08512
- and -
TERRENCE K. MARTIN, ESQ.
714 J. Clyde Morris Boulevard
Newport News, 23501-1500

Counsel on behalf of the Plaintiff

ROBERT L. HARRIS, JR., ESQ.
ALLEN & ALLEN
Federal Reserve Bank Building
701 East Byrd Street, 16th Floor
Richmond, Virginia 23219
Counsel on behalf of Defendant
Riverside

Reported by: Victoria L. DeBerry

[p.86]

Defendants' Exhibit 2.

(Whereupon, Defendants' Exhibit Nos. 1 and 2 were marked and received into evidence.)

THE COURT: I have entered the order that was presented to me today. I've entered it September 15,2006. It's been endorsed. I think each of you have objected to something. But anyway, I've entered that.

Now, as to an order for today, first of all, I'm going to find that this cause was unreasonable and without foundation brought, and I'm going to award costs and attorney's fees.

Now, as to costs, they'll be all taxable court costs and deposition and court reporter costs. And attorney's fees I find are reasonable that you have given to me, Mr. Harris. But I am going to start that, in other

* * *

APPENDIX E

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394EH

[Filed October 31, 2006]

PAUL J. MEYERS, M.D., Plaintiff,	)
v.	)
RIVERSIDE HOSPITAL, INC., *et al.*, Defendants.	)

FINAL ORDER

THIS DAY CAME the parties, by counsel, upon the Defendants' *Motion for Attorneys' Fees*. The Court has reviewed the parties' respective Memoranda of Law regarding the reasonableness of the fees and costs incurred by the Defendants, as well as the propriety of Dr. Meyers' filing and pursuing this action. The Court notes preliminarily that Dr. Meyers does not contest the reasonableness of the Defendants' fees and costs. Having considered the parties' respective positions and the arguments of their counsel, the Court finds that Dr. Meyers' conduct in this litigation has been

unreasonable. For the period beginning April 10, 2003, and concluding on April 20, 2006, the Court awards the Defendants attorneys' fees in the amount of $91,016. The Court also awards the Defendants court costs in the amount of $1,268.48. Having made these rulings, the Court enters judgment against Dr. Meyers in the sum of $92,284.48, with interest accruing at the judgment rate from the date of judgment until payment in full.

The parties' objections lodged in all previous orders are preserved.

Having disposed of all issues, the Court dismisses this action with prejudice and requests the Clerk of Courts to place it among the ended causes.

ENTER: Oct / 31 / 06

/s/
Judge John Clarkson

The Defendants ask for the award of attorneys' fees and costs but object to the amount awarded:

/s/
Robert L. Harris, Jr., Esquire (VSB 33454)
LECLAIR RYAN, A Professional Corporation
The Federal Reserve Bank Building
701 East Byrd Street, 16th Floor
Post Office Box 2499
Richmond, Virginia 23218-2499
Telephone: (804) 545-1505
Facsimile: (804) 545-1501

Seen and objected to for the reasons stated in the record:

/s/_____
Terrence K. Martin, Esquire
714 J. Clyde Morris Boulevard, Suite 140
Newport News, Virginia 23601

Nicholas Kadar, M.D., J.D.
11 Jackson Court
Cranbury, New Jersey 08512

APPENDIX F

July 27,2005

Nicholas Kadar, M.D., Esq.
11 Jackson Court
Cranbury, New Jersey 08512

Robert L. Harris, Jr., Esq.
LeClair Ryan
P. O. Box 2499
Richmond, Virginia 23218-2499

Paul J. Meyers, M.D. v. Riverside Hospital, *et al.*
At Law No. 31394-EH

Dear Counsel:

This law action is now before this Court on Defendants' demurrer to Meyers Third Amended Motion for Judgment.

Plaintiff alleges defamation (multiple counts) in Count I (264-302), tortuous interference with contract expectancy in Count II (303-319) and seeks monetary damages.

Defendants demur citing in part Health Care Quality Improvement Act, 42 U.S.C. § 11101 ("HCQIA") which immunizes the participants in the peer review process from liability "in damages under

any law of the United States or any State" if the peer review "meets all the standards specified in § 1112(a) of this title 42 U.S.C. § 111(a).

I find from the exhibits and argument of counsel that the standards for professional review actions have been fulfilled. The standards necessary for protection have not been rebutted by a preponderance of the evidence.

The issue now presents in 42 U.S.C. § 1111(a)(2) as plaintiff *alleges* person or persons providing information to the review body gave false information "and the persons providing it knew that such information was false". If true, the defendants' lose all immunity under "HCQIA".

As to Count I, the demurrer is overruled.

As to Count II, the demurrer is sustained and dismissed without leave to amend for reasons previously stated in that sufficient facts to state a cause of action have not been pled.

I request Nicholas Kadar, M.D., Esq. to prepare an order consistent with this opinion and after endorsement by counsel, forward to me for entry.

I am most appreciative of your extensive "briefing" and professional handling of this action.

Respectfully yours,
/s/
John E. Clarkson
Retired Judge

APPENDIX G

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394EH

[Filed August 16, 2005]

PAUL J. MEYERS, M.D., Plaintiff,	)
v.	)
RIVERSIDE HOSPITAL, INC., et al., Defendants.	)

ORDER

THIS MATTER came before the Court on the Defendants' Demurrer to the Plaintiff's Third Amended Motion for Judgment for Defamation (Count I) and Tortious Interference with Contract Expectancy (Count II) and Motion Craving Oyer. The Motions were argued by counsel for the Plaintiff and the Defendants on June 23, 2005, and the parties were granted leave to submit further briefs. Having considered the Plaintiff's Third Amended Motion for Judgment, the briefs submitted by the parties, and the arguments of their counsel, it is accordingly

ADJUDGED and ORDERED that

(a) Defendants' Motion Craving Oyer is GRANTED with leave to append Plaintiff's Exhibits 58-67 attached to the Plaintiff's brief opposing the Motion;

(b) The Demurrer to Count I of the Third Amended Motion for Judgment for Defamation is OVERRULED;

(c) The Demurrer to Count II of the Third Amended Motion for Judgment for Tortious Interference with Contract Expectancy is SUSTAINED without leave to amend.

(d) The Defendants shall answer the Third Amended Motion for Judgment within 21 days after the date the Clerk of Court mails a copy of this Order to counsel of record.

Noting that Dr. Meyers has not named Urology of Virginia, Inc. in the *Third Amended Motion for Judgment* and that Dr. Meyers has requested the dismissal of that defendant with prejudice, the Court DISMISSES WITH PREJUDICE this action with respect to Urology of Virginia, Inc.

The Court directs the Clerk of Court to send a teste copy of this Order to counsel of record.

ENTER: 8 / 16 / 5

/s/
The Honorable John E. Clarkson

Seen and agreed to regarding all matters save the holding that the Defendants' actions complied with the statutory standards under the Health Care Quality Improvement Act

/s/

Nicholas Kadar,
11 Jackson Court
Cranbury, New Jersey 08512
Telephone: (609) 655-2459
Fax: (609) 395-9514

Terrence K. Martin
714 J. Clyde Morns Boulevard, Suite 140
Newport News, Virginia 23601
(757) 599-9822
(757) 599-9824 (fax)

Counsel for Plaintiff

Seen and agreed to regarding dismissal of Urology of Virginia, Inc., and the rulings on the Motion Craving Oyer and the Demurrer to Count II but objected to the granting of leave to Dr. Meyers to include more exhibits on Demurrer and the overruling of the Demurrer to Count I:

/s/

Everette G. Allen, Jr. (VSB #05197)
Robert L. Harris, Jr. (VSB #33454)
LECLAIR RYAN, A PROFESSIONAL CORPORATION
Federal Reserve Bank Building

APPENDIX H

TITLE 42 – THE PUBLIC HEALTH AND WELFARE
CHAPTER 117 – ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

42 U.S.C. § 11101. Findings

The Congress finds the following:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from

participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

SUBCHAPTER I – PROMOTION OF PROFESSIONAL REVIEW ACTIVITIES

42 U.S.C. § 11111. Professional review

(a) In general

(1) Limitation on damages for professional review actions

If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title, except as provided in subsection (b) of this section –

(A) the professional review body,

(B) any person acting as a member or staff to the body,

(C) any person under a contract or other formal agreement with the body, and

(D) any person who participates with or assists the body with respect to the action,

shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964,42 U.S.C. § 2000e, et seq. and the Civil Rights Acts, 42 U.S.C. § 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 15c of title 15, where such an action is otherwise authorized.

(2) Protection for those providing information to professional review bodies

Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.

* * *

42 U.S.C. § 11112. Standards for professional review actions

(a) In general

For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken –

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

* * *

(c) Adequate procedures in investigations or health emergencies

For purposes of section 11111(a) of this title, nothing in this section shall be construed as –

(1) requiring the procedures referred to in subsection (a)(3) of this section –

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

42 U.S.C. § 11113. Payment of reasonable attorneys' fees and costs in defense of suit

In any suit brought against a defendant, to the extent that a defendant has met the standards set forth under section 11112(a) of this title and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a

reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unseasonable, without foundation, or in bad faith. For the purposes of this section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

42 U.S.C. § 11115. Construction

(a) In general

Except as specifically provided in this subchapter, nothing in this subchapter shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law which provides incentives, immunities. or protection for those engaged in a professional review action that is in addition to or greater than that provided by this subchapter.

* * *

42 U.S.C. § 11151. Definitions

In this chapter:

(1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity

* * *

(4)(A) The term "health care entity" means –

(i) a hospital that is licensed to provide health care services by the State in which it is located,

* * *

(8) The term "physician" means a doctor of medicine or osteopathy. . . legally authorized to practice medicine and surgery. . . by a State. . .

(9) The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this chapter, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on –

(A) the physician's association, or lack of association, with a professional society or association,

(B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,

(C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or

(E) any other matter that does not relate to the competence or professional conduct of a physician.

(10) The term "professional review activity" means an activity of a health care entity with respect to an individual physician –

(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,

(B) to determine the scope or conditions of such privileges or membership, or

(C) to change or modify such privileges or membership.

(11) The term "professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

APPENDIX I

99th CONGRESS
2D SESSION

H.R. 5110

To encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES
June 26, 1986

MR. WYDEN (for himself, MR. WAXMAN, MR. MADIGAN, and MR. TAUKE) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE

This Act may be cited as the "Health Care Quality Improvement Act of 1986".

* * *

SEC. 102. STANDARDS FOR A PROFESSIONAL REVIEW BODY.

(a) IN GENERAL.—The standards of this subsection, with respect to a professional review action, are that the action is taken—

(1) in good faith in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate due process to the physician or other licensed health care practitioner involved, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after the due process described in paragraph (3).

A professional review action is presumed to have been taken in good faith in the furtherance of quality health

care unless it is shown, by clear and convincing evidence, to the contrary.

* * *

SEC. 103. PAYMENT OF REASONABLE ATTORNEYS' FEES AND COSTS IN DEFENSE OF SUIT.

In any suit brought against a defendant, to the extent that section 101 applies with respect to the defendant and the defendant substantially prevails, the defendant shall be entitled to recover from the plaintiff reasonable attorneys' fees plus costs in defense of the suit.

APPENDIX J

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31395-EH

[April 20, 2006]

PAUL J. MEYERS, M.D.,
Plaintiff,

v.

RIVERSIDE HOSPITAL, INC., t/a RIVERSIDE REGIONAL MEDICAL CENTER, et al.
Defendants.

BEFORE: The Honorable John E. Clarkson, Judge

DATE: April 20, 2006

Reported by: Victoria L. DeBerry

[p.53]

documents in those files, documents in those files, and they're all immune for this because the hospital is

immune. That means from now on, they can publish and say about this man beloved by the residents that he asked a nurse to alter a clinical trial variance. If this Court believes that Congress intended that, I, with the deepest respect for the Court, disagree with that. Congress could not possibly have ever intended that. Thank you.

MR. HARRIS: May I have a brief rebuttal, Your Honor?

THE COURT: You certainly may.

MR. HARRIS: Judge, I thought for a few minutes there we were hearing argument on the facts. This case is in a posture from a legal standpoint at which part of HCQIA applies. If Your Honor gets into examining the facts again, Your Honor is doing expressly what Congress and the courts uniformly have said, and that is we're not here to substitute our judgment for that of the hospital body. In fact, Your Honor said two years ago that I'm not going to second-guess the doctors, and I have a transcript of it. But you granted leave to amend. If due process is afforded through an administrative action that satisfies HCQIA, then that's what you're entitled to and immunity flows from that.

The Virginia Supreme Court said, thank you, that we tried -- our goal is to reconcile provisions to

[p.60]

case against one of its administrators.

So, Your Honor, Judge Conway decided this case I'd say close to the last minute. I'm asking Your Honor to reconsider this in light of what we advanced before, but also in light of what we've advanced since.

And I think Dr. Kadar said that I hadn't explained why I didn't bring up the *Jenkins* case before. I thought it was the first thing I said, was that it was my fault I didn't find it, shame on me, I wish I had found it sooner, I wish I had conversed with counsel here, maybe we could have colluded and conspired on this legal argument. I'd be maybe a defendant in a case coming forward, who knows. But I ask Your Honor to reconsider the demurrer, to sustain it and dismiss the action with prejudice.

THE COURT: I'll certainly reconsider.

DR. KADAR: May I make a motion, because I think I forgot the other point, Your Honor, because Your Honor was away? I read the rules, and you need the Court's permission to file a brief more than 20 pages, and I would like the Court's permission to file a motion for reconsideration of Riverside's immunity based on the evidence that we have acquired through discovery to show that they did not satisfy the requirement of (a)(2) and (a)(4), and I would like permission to file it, because obviously I can't cover that in a brief less than 20 pages.

[p.61]

THE COURT: All right, counsel, I would like to get this case going somewhere.

DR. KADAR: We do too, Your Honor. Can I just say that we are in fact --

THE COURT: Do you want to file some motions?

DR. KADAR: Well, I mean --

THE COURT: Let's get all the filings in and then I'm going to ask that the record be typed up. You all know this case so much better than I'll ever know it, so I want to take advantage of what you've said to me today. Why don't you take ten days to file whatever you want.

DR. KADAR: Your Honor, can I throw myself at the mercy of the Court. I've just been bombarded with briefs from Yale, so can I --

THE COURT: You can have all the time you want. How much time do you want?

DR. KADAR: I'll do it within, for sure, three weeks. I'll try and do it before.

THE COURT: I'll give you a month, I'll give you a month.

MR. HARRIS: Your Honor, let me --

THE COURT: Get the record typed up, and then I'm going to come over here and spend a couple of days and I'm going to read it all and I'll write an opinion.

APPENDIX K

July 1 , 2000

RE: Paul Meyers, MD

Dear Dr. Kauder,

I am writing to you in support of Dr. Paul Meyers. I have known him over my five years of training here at Riverside. I have found him an extremely valuable asset in terms of my training, and to the residency program as a whole. In particular, he has provided me with a breadth and depth in laparoscopic procedures that I doubt I would find at any other program in Virginia. Collectively, as residents, we have sought him out to perform our most challenging laparoscopic cases, like those involving abcesses, large benign pelvic masses, and endoscopic suturing. He has always exercised extreme caution when proceeding in such cases and in even in spite of that, encountered complications, which were more a result of the pathology involved, rather than his skill or technique. He has also shown an uncanny ability to recognize those complications, and manage them laparoscopically when possible, and conventionally when appropriate. He has given me the opportunity to exercise discretion in the management of my cases in a controlled environment. This has been crucial to my training as a gynecologist. I think I speak for most if not all resident when I say that the training program will miss his skill and guidance.

Sincerely,

/s/
Michael Seryakov, M.D.

JUDITH A. GURDIAN, M.D. AND ASSOCIATES, P.D.
OBSTETRICS AND GYNECOLOGY
1500 RESEARCH BOULEVARD, SUITE 100
ROCKVILLE, MD 20850

Judith A. Gurdian, M.D.
Steve Behram, M.D.
Patricia E. Shevock, P.A.-C.

Bruce Kauder, M.D.
Medical Staff President
Riverside Regional Medical Center
500 J. Clyde Morris Blvd
Newport News, V A 23601

July 10, 2000

Dear Dr. Kauder,

This letter is to me as a letter of reference on behalf of Dr. Paul J. Meyers. I have known Dr. Meyers during all the phases my of training and practice; beginning as a third-year medical student in 1993, as a fourth-year medical student in 1994, as an OB/GYN resident from 1994 through 1998, and as a faculty member and professional colleague from 1998 to the current time. As such, I hope that my perspective may be of value to you and your colleagues in your evaluation of Dr. Meyers.

Under the instruction of Dr. Meyers, I was able to develop an extensive array of advanced laparoscopy skills that would otherwise not have been possible at Riverside Hospital. Dr. Meyers has been the only faculty member offering laparoscopic Burch training

among other complicated pelviscopic procedures. As residents, we would commonly post our most complicated and surgically demanding laparoscopic cases with Dr. Meyers. In fact, I continued to operate with Dr. Meyers on my most complicated cases in the private setting because of his extensive experience in this particular field.

During my years with Dr. Meyers I have always known him to act in a professional and ethical matter. He has consistently demonstrated excellent decision-making skills during the cases that we have shared over the years, His departure from residency training program will create a significant educational deficit which will be very difficult to overcome. His potential loss from the community will forever deprive the region of this skilled physician and surgeon.

Cordially,
/s/
Steve Behram. M.D.

cc: Rudolph Freeman, M.D.
Paul J. Meyers, M.D.

APPENDIX L

RIVERSIDE
HAMPTON ROADS GYN ONCOLOGY

To: Karen Bruder, MD FACOG, Chairman of the Department of Obstetrics and Gynecology, Riverside Regional Medical Center

From: William J Mann, Jr MD FACOG FACS MBA

September 19, 1999

Re: Mentorship of Paul Meyers, MD FACOG

I have completed the mentorship of Dr. Paul Meyers' endoscopic surgery at Riverside Regional Medical Center, and am writing this memo in response to a request for it from Dr. Bruder and Freeman. A one page form, provided by Dr. Freeman, was filled out for each case and returned to Dr. Freeman. No entrees were made in the medical record, and no copy of this form was added to any medical record, in accordance with Dr. Freeman's instructions to me.

I have reviewed with Dr. Meyers the indication for surgery in each case, and without exception I found that the proposed procedures were indicated and appropriate, and that patient selection was sound.

I have also reviewed the medical records for each patient, discussed the pre-operative patient

preparation for each case, and again found without exception that appropriate pre-operative patient care had been administered.

I directly observed all the operative procedures in the operating suite, and in every instance, the surgical skills evidenced by Dr. Meyers were excellent. In fact, he may very well be the most accomplished laparoscopic surgeon at our medical center, and certainly is the most experienced in the use of endoscopic techniques for pelvic floor reconstruction.

In each case, I confirmed that informed consent had been obtained and was properly documented, and that each and every records was complete and accurate. The medical records were very complete.

I discussed the post-operative care with Dr. Meyers and with the OB/GYN housestaff for each patient, and found the post-operative care to be appropriate and reasonable. The patient outcomes were uniformly very good.

During the mentorship, I also noted that several attending physicians (Dr. Thom, Dr. Tim O'Connel, Dr. Coyle, Dr. Behram) as well as myself, requested Dr. Meyers opinion with respect to the endoscopic management of specific private patients. I believe this demonstrates recognition by attending physicians in Obstetrics and Gynecology of Dr. Meyers' exceptional expertise in endoscopic surgery.

In my opinion, Dr. Meyers is a competent and talented endoscopic surgeon, and is a valuable part of our local medical community. I have never understood why his

privileges were restricted, as the apparent result of his having experienced recognized and accepted surgical complications, which were appropriately managed, but I believe my period of close observation of his endoscopic skills confirms what a significant proportion of the gynecologic community already recognizes, namely that he is a competent, skilled gynecologic endoscopist. Indeed, our medical community could profit considerably from Dr. Meyers sharing his skills with his colleagues, something he willingly does.

APPENDIX M

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394EH

[May 19, 2003]

PAUL J. MEYERS, M.D.,
Plaintiff,

v.

RIVERSIDE HOSPITAL, INC., et al.,
Defendants.

DEPOSITION OF CARL J. LEVINSON
May 19, 2003

[p.226]

Q. Well, I don't have the nurse's notes.

A. - - because they say the only complaint was dysuria.

Q. On the 13th when she came back?

A. How about the admitting note?

Q. Well, Doctor - -

A. No. I'm trying to point out that if she had sudden abdominal pain - -

Q. You wouldn't be critical?

A. I wouldn't have been critical.

Q. But you could have called up, couldn't you?

A. I could have called up on every case.

Q. Well, you didn't have in every case deficient operative notes? You didn't have absent operative notes on every case, did you?

A. No. I had a lot of things missing on almost every case. Do you have that nurse's admitting note?

* * *

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send you copies. It's just so I remember what it is.

A. I'm wondering if I looked at her pathology report at all, because the questionable secretory endometrium, some evidence of adenomyosis and one small myoma just doesn't exist for this patient.

BY MR. KADAR:

Q. Knowing what we know now, would you perhaps revise your opinion that the indications were questionable in this patient?

A. Yes, there were good indications for surgery.

* * *

APPENDIX N

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31395-EH

[April 9, 2003]

PAUL J. MEYERS, M.D.,
Plaintiff,

v.

RIVERSIDE HOSPITAL, INC., t/a RIVERSIDE REGIONAL MEDICAL CENTER, et al.
Defendants.

BEFORE: The Honorable John E. Clarkson, Judge

DATE: April 9, 2003

APPEARANCES: NICHOLAS KADAR, ESQ.
11 Jackson Court
Cranbury, New Jersey 08512
- and -
TERRENCE K. MARTIN, ESQ.
714 J. Clyde Morris Boulevard

Newport News, 23501-1500
Counsel on behalf of the Plaintiff

ROBERT L. HARRIS, JR., ESQ.
ALLEN & ALLEN
Federal Reserve Bank Building
701 East Byrd Street, 16th Floor
Richmond, Virginia 23219
Counsel on behalf of Defendant
Riverside

KRISTAN B. BURCH, ESQ.
Kaufman & Canoles
150 West Main Street, Suite 2100
Norfolk, Virginia 23510-1609
Counsel on behalf of Defendant
Partridge

Reported by: Victoria L. DeBerry

[p.158]

THE COURT: There shouldn't be a problem.

DR. KADAR: I agree, I agree. I thought we would say yes, these are authentic and that would be it, and it was much to my amazement everybody --

THE COURT: Okay. We'll get to that. If there is a problem, we'll get to it early.

MR. HARRIS: Thank you, Judge.

DR. KADAR: Judge, I am conscious that we have exasperated you, and I thank you for your --

THE COURT: No, you haven't exasperated me, not yet. We'll get there. You-all are spending an awful lot of time --

DR. KADAR: But it's very important, Your Honor. This man's entire career is at stake here.

THE COURT: But I can't -- I have a hard time believing that a group of doctors are so evil.

DR. KADAR: Well, you see, this is what is of major --

THE COURT: A lot of my good friends are doctors. Maybe there's no guilt by association.

DR. KADAR: This is what is of major concern to me, this cannot be decided on one's experience of doctors.

THE COURT: Most doctors are A students, most lawyers are B students. Every time I go to a doctor,

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I'm so thankful they were so smart. And you know, most doctors -- I don't know of a bad doctor, and I've been trying cases for over 40 years. I may not agree with doctors and doctors don't agree with themselves, every medical malpractice case I get, there's going to be two sides and they're both positive, but I don't know of any evil doctors that are going to gang up on -- I mean, I look at him and he looks like an awful nice guy

* * *

APPENDIX O

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394-EH

[June 23, 2005]

PAUL J. MEYERS, M.D., Plaintiff,	)
v.	)
RIVERSIDE HOSPITAL, INC., t/a RIVERSIDE REGIONAL MEDICAL CENTER, et al. Defendants.	)

BEFORE: The Honorable John E. Clarkson, Judge

DATE: June 23, 2005

APPEARANCES: NICHOLAS KADAR, ESQ.
11 Jackson Court
Cranbury, New Jersey 08512
- and -
TERRENCE K. MARTIN, ESQ.
714 J. Clyde Morris Boulevard

Newport News, 23501-1500
Counsel on behalf of the Plaintiff

ROBERT L. HARRIS, JR., ESQ.
ALLEN & ALLEN
Federal Reserve Bank Building
701 East Byrd Street, 16th Floor
Richmond, Virginia 23219
Counsel on behalf of Defendant Riverside

Reported by: Victoria L. DeBerry

[p.89]

best I can do.

MR. HARRIS: That's fine.

THE COURT: What worries me, quite frankly, is it's on a demurrer. If it was a motion for summary judgment, it would be easy, but on a demurrer -- that's what I'm worried about.

MR. HARRIS: All we can ask is if you look at the entire --

THE COURT: I'll look at it.

MR. HARRIS: Thank you, Your Honor.

THE COURT: I think he may have -- may be staying in court, maybe. Okay.

DR. KADAR: Thank you, Your Honor.

THE COURT: Can I take this along because I don't

DR. KADAR: Sure, sure you can, Your Honor.

THE COURT: I don't need the notebook.

MR. HARRIS: May I just see what it is?

THE COURT: I guess it's the statute. I'm worried about who makes the decision, as I've told you two or three times. You know, quite frankly, if I was to make it, I think they did everything reasonably, you know, reasonable, may not be perfect, but it's reasonable, but I'm not sure that I make that decision.

APPENDIX P

RIVERSIDE
REGIONAL MEDICAL CENTER

December 30, 1998

Dr. Rudolph Freeman
Vice President of Medical Affairs
Riverside Regional Medical Center
500 J. Clyde Morris Blvd.
Newport News, VA 23601

Dear Rudolph,

All of this business about Dr. Paul Meyers has brought to my attention again that we need to reevaluate our credentialing process at this institution. This is particularly obvious when the credentials are different between the main Medical Center and the Surgical Center. In addition, with the possible fusion with Mary Immaculate Hospital coming up in the next six to twelve weeks, consideration of a "pan" system for credentialing would be very appropriate.

Secondly, having a committee that is responsible for a review of cases at the Surgery Center that is different from the one here at the Medical Center creates confusion. In fact, Dr. Meyers has received a letter from that committee at the Surgery Center, stating that his management of the laparoscopic case in question was entirely appropriate. That would tend

to make the Executive Committee look like a group of bumpkins, since we are evaluating him, partially at least, based on that case.

Thirdly, as I mentioned at the Executive Committee meeting before Christmas, there has been two other cases of fluid overload by other members of the gynecologic surgery staff in the hysteroscopic procedure. While I was told there was a written policy and procedure concerning this procedure, I have yet to see it and, in fact, no one seems to be able to put their hands on it. Anecdotally, Dr. Mann tells me the OR nurses have been very concerned about his. In fact, this procedure is such that he and I wonder if it should not be done here at the Medical Center rather than scheduled for outpatient surgery because of its potential for high risk complications.

Fourthly, I spoke with Mr. Brink recently about some changes in the medical record that occurred after the patient that Dr. Meyers had cared for this hysteroscopy was transferred to the Medical Center. The record certainly does not look the same and it may be an entirely innocent situation, but on the other hand, if there were to be any liability claims from this case, it certainly would not look good if an attorney were to find out about the post dating of medical records. I have provided through Dr. Meyers a copy of the two different sheets of paper from the medical record and if I were a paranoid individual, I would certainly wonder if someone was "out to get me". At any rate, Mr. Brink has those records and I am sure will share them with you.

Please let me know what I can do to assist as we go through this process. I was pleased to learn that we have an expert who is now contracted to review all of the records that were in question. There is some question in my mind, however, that there is now a difference in the listing of the medical records that were presented to the Medical Executive Committee verses the one that is apparently being questioned and reviewed.

Very Truly Yours,

/s/

T. Eugene Temple, Jr., M.D.

APPENDIX Q

Education and debate

Human error: models and management
James Reason

Department of Psychology,
University of Manchester,
Manchester
M13 9PL
James Reason
professor of psychology
reason@psy.man.ac.uk

BMJ 2000;320:768–70

The human error problem can be viewed in two ways: the person approach and the system approach. Each has its model of error causation and each model gives rise to quite different philosophies of error management. Understanding these differences has important practical implications for coping with the ever present risk of mishaps in clinical practice.

Summary points

Two approaches to the problem of human fallibility exist: the person and the system approaches

The person approach focuses on the errors of individuals, blaming them for forgetfulness, inattention, or moral weakness

The system approach concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effects

High reliability organisations—which have less than their fair share of accidents—recognise that human variability is a force to harness in averting errors, but they work hard to focus that variability and are constantly preoccupied with the possibility of failure

Person approach

The longstanding and widespread tradition of the person approach focuses on the unsafe acts—errors and procedural violations—of people at the sharp end: nurses, physicians, surgeons, anaesthetists, pharmacists, and the like. It views these unsafe acts as arising primarily from aberrant mental processes such as forgetfulness, inattention, poor motivation, carelessness, negligence, and recklessness. Naturally

enough, the associated countermeasures are directed mainly at reducing unwanted variability in human behaviour. These methods include poster campaigns that appeal to people's sense of fear, writing another procedure (or adding to existing ones), disciplinary measures, threat of litigation, retraining, naming, blaming, and shaming. Followers of this approach tend to treat errors as moral issues, assuming that bad things happen to bad people—what psychologists have called the just world hypothesis.[1]

System approach

The basic premise in the system approach is that humans are fallible and errors are to be expected, even in the best organisations. Errors are seen as consequences rather than causes, having their origins not so much in the perversity of human nature as in "upstream" systemic factors. These include recurrent error traps in the workplace and the organisational processes that give rise to them. Countermeasures are based on the assumption that though we cannot change the human condition, we can change the conditions under which humans work. A central idea is that of system defences. All hazardous technologies possess barriers and safeguards. When an adverse event occurs, the important issue is not who blundered, but how and why the defences failed.

Evaluating the person approach

The person approach remains the dominant tradition in medicine, as elsewhere. From some perspectives it has much to commend it. Blaming individuals is emotionally more satisfying than targeting

institutions. People are viewed as free agents capable of choosing between safe and unsafe modes of behaviour. If something goes wrong, it seems obvious that an individual (or group of individuals) must have been responsible. Seeking as far as possible to uncouple a person's unsafe acts from any institutional responsibility is clearly in the interests of managers. It is also legally more convenient, at least in Britain.

Nevertheless, the person approach has serious shortcomings and is ill suited to the medical domain. Indeed, continued adherence to this approach is likely to thwart the development of safer healthcare institutions.

Although some unsafe acts in any sphere are egregious, the vast majority are not. In aviation maintenance—a hands-on activity similar to medical practice in many respects—some 90% of quality lapses were judged as blameless.[2] Effective risk management depends crucially on establishing a reporting culture.[3] Without a detailed analysis of mishaps, incidents, near misses, and "free lessons," we have no way of uncovering recurrent error traps or of knowing where the "edge" is until we fall over it. The complete absence of such a reporting culture within the Soviet Union contributed crucially to the Chernobyl disaster.[4] Trust is a key element of a reporting culture and this, in turn, requires the existence of a just culture—one possessing a collective understanding of where the line should be drawn between blameless and blameworthy actions.[5] Engineering a just culture is an essential early step in creating a safe culture.

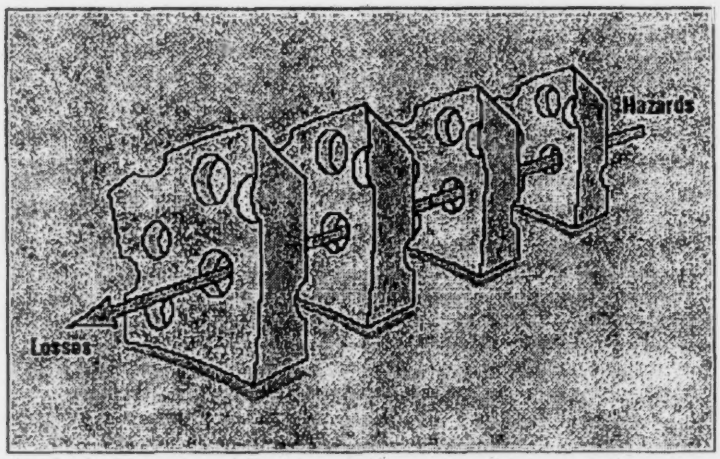
Another serious weakness of the person approach is that by focusing on the individual origins of error it isolates unsafe acts from their system context. As a result, two important features of human error tend to be overlooked. Firstly, it is often the best people who make the worst mistakes—error is not the monopoly of an unfortunate few. Secondly, far from being random, mishaps tend to fall into recurrent patterns. The same set of circumstances can provoke similar errors, regardless of the people involved. The pursuit of greater safety is seriously impeded by an approach that does not seek out and remove the error provoking properties within the system at large.

The Swiss cheese model of system accidents

Defences, barriers, and safeguards occupy a key position in the system approach. High technology systems have many defensive layers: some are engineered (alarms, physical barriers, automatic shutdowns, etc), others rely on people (surgeons, anaesthetists, pilots, control room operators, etc), and yet others depend on procedures and administrative controls. Their function is to protect potential victims and assets from local hazards. Mostly they do this very effectively, but there are always weaknesses.

In an ideal world each defensive layer would be intact. In reality, however, they are more like slices of Swiss cheese, having many holes—though unlike in the cheese, these holes are continually opening, shutting, and shifting their location. The presence of holes in any one "slice" does not normally cause a bad outcome. Usually, this can happen only when the holes in many layers momentarily line up to permit a

trajectory of accident opportunity—bringing hazards into damaging contact with victims (figure).



The Swiss cheese model of how defences, barriers, and safeguards may be penetrated by an accident trajectory

The holes in the defences arise for two reasons: active failures and latent conditions. Nearly all adverse events involve a combination of these two sets of factors.

Active failures are the unsafe acts committed by people who are in direct contact with the patient or system. They take a variety of forms: slips, lapses, fumbles, mistakes, and procedural violations.[6] Active failures have a direct and usually shortlived impact on the integrity of the defences. At Chernobyl, for example, the operators wrongly violated plant procedures and switched off successive safety systems, thus creating the immediate trigger for the catastrophic explosion in the core. Followers of the person approach often look no further for the causes of an adverse event once they have identified these

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proximal unsafe acts. But, as discussed below, virtually all such acts have a causal history that extends back in time and up through the levels of the system.

Latent conditions are the inevitable "resident pathogens" within the system. They arise from decisions made by designers, builders, procedure writers, and top level management. Such decisions may be mistaken, but they need not be. All such strategic decisions have the potential for introducing pathogens into the system. Latent conditions have two kinds of adverse effect: they can translate into error provoking conditions within the local workplace (for example, time pressure, understaffing, inadequate equipment, fatigue, and inexperience) and they can create longlasting holes or weaknesses in the defences (untrustworthy alarms and indicators, unworkable procedures, design and construction deficiencies, etc). Latent conditions—as the term suggests—may lie dormant within the system for many years before they combine with active failures and local triggers to create an accident opportunity. Unlike active failures, whose specific forms are often hard to foresee, latent conditions can be identified and remedied before an adverse event occurs. Understanding this leads to proactive rather than reactive risk management.

☐ *We cannot change the human condition, but we can change the conditions under which humans work*

To use another analogy: active failures are like mosquitoes. They can be swatted one by one, but they still keep coming. The best remedies are to create more effective defences and to drain the swamps in which

they breed. The swamps, in this case, are the ever present latent conditions.

Error management

Over the past decade researchers into human factors have been increasingly concerned with developing the tools for managing unsafe acts. Error management has two components: limiting the incidence of dangerous errors and—since this will never be wholly effective—creating systems that are better able to tolerate the occurrence of errors and contain their damaging effects. Whereas followers of the person approach direct most of their management resources at trying to make individuals less fallible or wayward, adherents of the system approach strive for a comprehensive management programme aimed at several different targets: the person, the team, the task, the workplace, and the institution as a whole.[3]

High reliability organisations—systems operating in hazardous conditions that have fewer than their fair share of adverse events—offer important models for what constitutes a resilient system. Such a system has intrinsic "safety health"; it is able to withstand its operational dangers and yet still achieve its objectives.

Some paradoxes of high reliability

Just as medicine understands more about disease than health, so the safety sciences know more about what causes adverse events than about how they can best be avoided. Over the past 15 years or so, a group of social scientists based mainly at Berkeley and the University of Michigan has sought to redress this imbalance by

studying safety successes in organisations rather than their infrequent but more conspicuous failures.[7 8] These success stories involved nuclear aircraft carriers, air traffic control systems, and nuclear power plants (box). Although such high reliability organisations may seem remote from clinical practice, some of their defining cultural characteristics could be imported into the medical domain.

High reliability organizations

[image omitted]

So far, three types of high reliability organisations have been investigated: US Navy nuclear aircraft carriers, nuclear power plants, and air traffic control centres. The challenges facing these organisations are twofold:

• Managing complex, demanding technologies so as to avoid major failures that could cripple or even destroy the organisation concerned

• Maintaining the capacity for meeting periods of very high peak demand, whenever these occur.

The organisations studied[7 8] had these defining characteristics:

• They were complex, internally dynamic, and, intermittently, intensely interactive

• They performed exacting tasks under considerable time pressure

• They had carried out these demanding activities with low incident rates and an almost complete absence of catastrophic failures over several years.

Although, on the face of it, these organisations are far removed from the medical domain, they share important characteristics with healthcare institutions. The lessons to be learnt from these organisations are clearly relevant for those who manage and operate healthcare institutions.

Most managers of traditional systems attribute human unreliability to unwanted variability and strive to eliminate it as far as possible. In high reliability organisations, on the other hand, it is recognised that human variability in the shape of compensations and adaptations to changing events represents one of the system's most important safeguards. Reliability is "a dynamic non-event."[7] It is dynamic because safety is preserved by timely human adjustments; it is a non-event because successful outcomes rarely call attention to themselves.

High reliability organisations can reconfigure themselves to suit local circumstances. In their routine mode, they are controlled in the conventional hierarchical manner. But in high tempo or emergency situations, control shifts to the experts on the spot—as it often does in the medical domain. The organisation reverts seamlessly to the routine control mode once the crisis has passed. Paradoxically, this flexibility arises

in part from a military tradition—even civilian high reliability organisations have a large proportion of ex-military staff. Military organisations tend to define their goals in an unambiguous way and, for these bursts of semiautonomous activity to be successful, it is essential that all the participants clearly understand and share these aspirations. Although high reliability organisations expect and encourage variability of human action, they also work very hard to maintain a consistent mindset of intelligent wariness.[8]

☐ *Blaming individuals is emotionally more satisfying than targeting institution.*

Perhaps the most important distinguishing feature of high reliability organisations is their collective preoccupation with the possibility of failure. They expect to make errors and train their workforce to recognise and recover them. They continually rehearse familiar scenarios of failure and strive hard to imagine novel ones. Instead of isolating failures, they generalise them. Instead of making local repairs, they look for system reforms.

Conclusions

High reliability organisations are the prime examples of the system approach. They anticipate the worst and equip themselves to deal with it at all levels of the organisation. It is hard, even unnatural, for individuals to remain chronically uneasy, so their organisational culture takes on a profound significance. Individuals may forget to be afraid, but the culture of a high reliability organisation provides

them with both the reminders and the tools to help them remember. For these organisations, the pursuit of safety is not so much about preventing isolated failures, either human or technical, as about making the system as robust as is practicable in the face of its human and operational hazards. High reliability organisations are not immune to adverse events, but they have learnt the knack of converting these occasional setbacks into enhanced resilience of the system.

Competing interests: None declared.

1 Lerner MJ. The desire for justice and reactions to victims. In: McCauley J, Berkowitz L, eds. *Altruism and helping behavior*. New York: Academic Press, 1970.

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3 Reason J. *Managing the risks of organizational accidents*. Aldershot: Ashgate, 1997.

4 Medvedev G. *The truth about Chernobyl*. New York: Basic Books, 1991.

5 Marx D. *Maintenance error causation*. Washington, DC: Federal Aviation Authority Office of Aviation Medicine, 1999.

6 Reason J. *Human error*. New York: Cambridge University Press, 1990.

7 Weick KE. Organizational culture as a source of high reliability. *Calif Management Rev* 1987;29:112-27.

8 Weick KE, Sutcliffe KM, Obstfeld D. Organizing for high reliability: processes of collective mindfulness. *Res Organizational Behav* 1999;21:23-81.

APPENDIX R

PENINSULA GASTROENTEROLOGY

Ernest P. Buxton, III, M.D.
John R. Stephens, M.D.
Ray L. James, Jr., M.D., F.A.C.P.
Frederick M. Gessner, M.D., F.A.C.G.
John W. Boyd, M.D.

June 1, 1999

Dr. Paul Meyers
328 Main Street
Newport News, VA 23601

RE: Betty [redacted]
#8904

Dear Paul,

Thanks for your letter regarding Betty [redacted]. This is a good result. I was very happy that a local surgeon was willing to take on this very complex lady and certainly happy with your fine care. I appreciate your prompt and thorough follow-up notes as well.

Sincerely,

/s/
FREDERICK M. GESSNER, M.D., F.A.C.G.

APPENDIX S

[p.95]

tie at the table is Dr. Kadar, who is counsel for Dr. Meyers who is seated at the table with him. And the members of the panel. If you would, swear in the witness.

(The witness was sworn.)

HEARING OFFICER CARPENTER: Doctor, I would ask if you would state your name for the record and spell your name.

THE WITNESS: Charles A. Miller, M-i-l-l-e-r.

HEARING OFFICER CARPENTER: You may examine, Dr. Kadar.

DR. KADAR: Thank you.

- - -

CHARLES A. MILLER, M.D.,
called as a witness, having been first
duly sworn, was examined and testified
as follows:

DIRECT EXAMINATION

* * *

[p.116]

* * *

DR. GALANTICH: Last question. Are the women of this community, are they better off not having Dr. Meyers do these procedures or do you think they've lost -- we've lost an asset , the community has lost an asset?

THE WITNESS: I think they have definitely lost an asset.

DR. GALANTICH: You didn't feel they were being put in any kind of danger to some of these procedures?

THE WITNESS: No.

* * *

APPENDIX T

RIVERSIDE
OB/GYN & FAMILY CARE

January 8, 1999

Gerald R. Brink
President
Riverside Regional Medical Center
500 J. Clyde Morris Blvd.
Newport News, VA 23601

Dear Mr. Brink:

It has come to my attention that the Executive Committee is reviewing the endoscopy privileges of my colleague, Dr. Paul Meyers. I feel compelled to write in his support. I have known Dr. Meyers since arriving on the peninsula in 1992, and have been associated with him professionally since joining the OB/GYN faculty at Riverside in July, 1994.

During that time, I have been most impressed with his surgical skills, particularly in performing laparoscopic and urogynecologic procedures. In fact, I have often asked Dr. Meyers to assist me in the operating room when facing a difficult case or one I felt may be beyond my level of surgical skills. During the past four years operating with him has increased my proficiency with laparoscopic suturing and dissection and my understanding of defects of the female pelvic floor.

Thanks to his proctoring, I am now able to offer my patients a broader range of laparoscopic and urogynecologic procedures, including suburethral sling procedures and abdominal sacrocolpopexies.

I have also been fortunate to work with Dr. Meyers at our private office, Hilton Women's Care. I have found him to be a conscientious, compassionate physician whose patients are delighted with his care. As he is knowledgeable in all aspects of urogynecology, I refer many of my patients to him for urodynamic or pelvic floor evaluation prior to planning any surgical procedure. He is often able to suggest alternatives to surgery or offers his assistance on a procedure that I would be unable to perform alone. For this, my patients and I are very grateful.

Dr. Meyers is also a dedicated and superb teacher, spending many hours each week patiently instructing our OB/GYN residents in conferences, the outpatient office and the operating room As a faculty member who was once in private practice, I can attest that it is much more difficult and time-consuming to teach a resident to manage a patient's care and perform a surgical procedure than it is to just do it yourself. In fact, the pressure from both internal and external sources to do exactly that is sometimes overwhelming. It is a rare talent to be able to with stand those pressures and continue teaching while still providing adequate patient care. I personally applaud Dr. Meyers efforts at teaching state of the art medicine to our residents.

Thank you for your time in considering my opinion on this matter. I would request that you share this letter

with the other members of the Executive Committee. I feel it would be a grave mistake to suspend Dr. Meyers endoscopy privileges and jeopardize his promising career. Our patients and residents would surely regret such an action.

With regards,

/s/
Karen L. Bruder, M.D., FACOG
Assistant Director, OB/GYN Residency Program
Riverside Regional Medical Center

84 2

No. 07-969

FILED
FEB 25 2008
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The
Supreme Court of the United States

PAUL J. MEYERS, M.D.,
Petitioner,

V.

RIVERSIDE HOSPITAL, T/A RIVERSIDE REGIONAL MEDICAL CENTER; RUDOLPH FREEMAN, JR., M.D.; RICHARD HOEFER, M.D.; CHARLES FAULK, M.D.; BRUCE KAUDER, M.D.; AND PAUL REIN, M.D.,
Respondents.

On Petition for Writ of Certiorari to the Supreme Court of Virginia

BRIEF IN OPPOSITION

Robert L. Harris, Jr., Esquire
LECLAIRRYAN, A Professional Corporation
Riverfront Plaza, East Tower, 8th Floor
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Post Office Box 2499
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Facsimile: (804) 916-7666

Counsel for the Respondents

LANTAGNE LEGAL PRINTING
801 East Main Street Suite 100 Richmond, Virginia 23219 (800) 847-0477

RESTATEMENT OF QUESTIONS PRESENTED

I. AS A THRESHOLD ISSUE, DOES THE COURT OR THE JURY DECIDE WHETHER A PROFESSIONAL REVIEW ACTION SATISFIES THE STANDARDS OF THE HEALTH CARE QUALITY IMPROVEMENT ACT?

II. DID THE TRIAL COURT APPLY AN OBJECTIVE REASONABLENESS STANDARD WHEN EVALUATING WHETHER THE PEER REVIEW ACTION WAS REASONABLE?

III. DID THE TRIAL COURT PROPERLY CONCLUDE THAT DR. MEYERS' ACTIONS WERE UNREASONABLE AND, THEREFORE, DID IT PROPERLY EXERCISE ITS DISCRETION WHEN AWARDING RIVERSIDE A PORTION OF ITS ATTORNEY'S FEES?

PARTIES TO THE PROCEEDING

All of the individual respondents are named in the caption of the case. For ease of reference, respondent Riverside Hospital, Inc., and the individual respondents shall be referred to as "Riverside."

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APPENDIX

A. January 13, 1999, Letter of Dr. Jay M. Cooper, M.D. to Dr. Freeman

B. Riverside Regional Medical Center Panel Hearing, May 23, 2001

C. *Brandi M. Penny v. Paul J. Meyers, M.D.*, Motion for Judgment, Newport News Circuit Court

D. September 25, 2000, Letter of John R. Partridge, M.D. to Thomas T. Thames, II, M.D.

E. December 26, 2000, Report of Jordan C. Pritzker, M.D.

F. Investigative Committee Report, July 15, 2000

G. June 8, 2001, Letter of William B. Downey to Paul Meyers, M.D.

H. Affidavit of Paul J. Meyers, M.D., December19, 2007

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OPINION BELOW

Riverside substantially concurs with Dr. Meyers' recitation of the trial court's letter opinions and orders in his Appendix to the *Petition for Writ of Certiorari.* The only material misstatements relate to (1) the trial court's ruling on Riverside's initial *Demurrer*[1] to Dr. Meyers' action and (2) when Riverside first pleaded the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. § 11101 *et seq.,* as an affirmative defense.

Contrary to Dr. Meyers' suggestion, the trial court did not sustain any general *Demurrer* to his count for defamation. In fact, Riverside did not demur entirely to that count. A previous co-

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[1] A demurrer is akin to a 12(b)(6) motion: has the plaintiff stated a cause of action upon which relief can be granted?

defendant, which is not a party to this appeal, demurred to that count, and Riverside, as a corporate defendant, demurred only to the extent that Dr. Meyers sought punitive damages against the hospital for allegedly defamatory statements that Dr. Meyers did not contend that Riverside had ratified. The trial court sustained the demurrer on those bases alone and not to the count for defamation in its entirety.

Moreover, Riverside did not wait until Dr. Meyers filed his *Third Amended Motion for Judgment* to plead HCQIA as an affirmative defense. In fact, Riverside invoked that defense upon Dr. Meyers' filing of his *Second Amended Motion for Judgment* two years earlier. Riverside's reason for delay is clear from the record below: in previous filings Dr. Meyers had not pleaded enough facts,

ironically, to demonstrate on the face of the pleadings that Riverside's peer review action was reasonable. In effect, as Dr. Meyers' description of the peer review process mushroomed in each amendment, he disclosed more of the due process afforded to him. In effect, Dr. Meyers pleaded away his case.

STATEMENT OF THE CASE

This Court expects counsel to disclose in a brief in opposition all perceived misstatements of facts or law. *See* Sup. Ct. R. 15(2). The trial court disposed of this case by deciding as a matter of law that Dr. Meyers' allegations fail to state a cause of action. Before ruling, the trial court considered the allegations and documents in the *Third Amended Motion for Judgment,* as amplified by Dr. Meyers' *Motion for Reconsideration,* as well as additional

documents that Riverside placed in the record that Dr. Meyers had described but not included in his pleadings. Although Dr. Meyers does not openly challenge the trial court's finding that Riverside's peer review action was reasonable, he does inject allegations designed to taint this Court's perception of Riverside. Any thoughtful review of the trial court's basis for ruling requires a more complete presentation of the facts.[2]

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[2] In fact, many more admissions by Dr. Meyers should have been before the trial court even before consideration of Riverside's third *Demurrer*. Over a year before trial court dismissed the case based on the insufficiency of Dr. Meyers' allegations, Riverside moved for summary judgment based not only on the allegations in the *Second Amended Motion for Summary Judgment* but also on Dr. Meyers' answers to requests for admissions. The trial court, however, granted Dr. Meyers leave to file a *Third Amended Motion for Judgment* instead of requiring him to respond to Riverside's *Motion for Summary Judgment*.

Riverside's concern about Dr. Meyers' surgical practice did not begin on March 1, 2000, when it summarily suspended him for causing five injuries during surgery in less than four months. His suspension on that date was the second in sixteen months and arose only four months after he had completed a remedial proctorship.

The first suspension arose from a patient's having a heart attack during surgery while Dr. Meyers removed uterine fibroids. During that procedure Dr. Meyers used fluids to distend, or expand, the patient's uterus. If a patient absorbs excessive volumes of distension fluid into her bloodstream, she may have seizures, experience brain damage or even die from cardiac arrest. Consequently, proper monitoring of fluid intake and

output is essential. This patient had a heart attack during surgery.

Dr. Meyers aborted the procedure and administered CPR; the patient survived. Then and now Dr. Meyers deflected blame for her complication: a "lack of fluid balance protocols and forms on which to record fluid balance, lack of [a] closed-circuit system to measure fluid balance accurately, and lack of equipment to measure electrolytes on the premises" caused the patient to suffer a heart attack. *Petition* at 33 (n.14). Although Dr. Meyers is quick to point out that Riverside's external reviewer of the patient's chart made these observations, Dr. Meyers fails to disclose that reviewer's observations *directed at him.*

Specifically, the reviewer remarked that at the time of the heart attack, Dr. Meyers and the

attending nurses could not account for approximately 5000cc's of distension fluid, which volume is over three times the limit that should trigger an immediate termination of the surgery. *See* App. A-1, -2.[3] Noting Dr. Meyers' concern over a fluid deficit forty minutes into the procedure, the external reviewer also observed that Dr. Meyers continued the surgery another eighty minutes despite his not having received the results of two tests to determine the extent of absorption of the distension fluid into the patient's bloodstream. "Under no circumstances should an operative hysteroscopic resection of a uterine fibroid extend beyond an hour and 30 minutes." *Id.* A-2. This patient's procedure stopped abruptly after two

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[3] Dr. Meyers belatedly introduced this report in his *Motion for Reconsideration.*

hours—and only after she went into cardiac arrest. The external reviewer declared,

> The physician was either unconcerned or ignored the potential complication . . . . A lack of clinical judgment was evident in continuing the surgical procedure 50 minutes after asking for an electrolyte determination, administering Lasix and, apparently, being informed by the circulating nurse that the fluid deficit was increasing. . . . [S]eizures, permanent brain damage and death can occur.

Id. Dr. Meyers conveniently ignores these criticisms. In doing so, he also ignores his own admission of responsibility at an internal hearing convened to address his clinical judgment. Asked whether he exhibited "impaired intraoperative clinical judgment" during this patient's surgery, Dr. Meyers conceded, "I think I miscalculated, and I think that—and I think I made a mistake. I think we

all have. Everybody has 10 or 15 minutes in their lives that they'd rather relive." App. B-1.[4]

Dr. Meyers had completed his first proctorship as of March 1, 2000. On that date, however, Riverside's Director of Surgical Services reported the fifth of five injuries sustained by Dr. Meyers' patients within only a three-month period after conclusion of the first proctorship. Those facts prompted Riverside, in full compliance with its Bylaws, to suspend Dr. Meyers' privileges summarily so that Riverside could investigate the cause of the complications. Given the information at hand, Riverside believed that "the failure [to summarily suspend Dr. Meyers] may result in an

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[4] Dr. Meyers avoided this admission in multiple amendments to his original Motion for Judgment. Nonetheless, in responses to requests for admissions, he admitted previously making this concession

imminent danger to the health of any individual." 42 U.S.C. § 11112(c)(2).

Emphasizing that none of the patients suffered "mortality or permanent injury," *Petition* at 8, again Dr. Meyers fails to disclose all of the material facts. Dr. Meyers perforated the rectum of one of the five patients, who was being treated for endometriosis, but he failed to notice the complication until two days after surgery, at which time she underwent a colostomy to correct the injury. That patient filed a civil action against Riverside and Dr. Meyers almost two years later—well after Riverside restored Dr. Meyers' privileges subject to a second proctorship. *See* App. C-1 through C-3.[5]

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[5] Virginia permits its courts to take judicial notice of court records. The parties settled all claims, the terms of which are confidential.

Riverside's Medical Executive Committee ("MEC") appointed an investigative subcommittee to examine the most recent surgical complications. Contrary to Dr. Meyers' assertion that the subcommittee "relied exclusively on the report of an external reviewer," *Petition* at 9, it actually reviewed peer review actions involving Dr. Meyers in 1995, 1996 and 1999, interviewed Dr. Meyers, and considered the reports of Riverside's outside reviewer and a consultant hired by Dr. Meyers.

Examining each patient's chart, Riverside's external reviewer both praised and criticized Dr. Meyers on a case-by-case basis. Although the reviewer acknowledged in one case that "there were good indications for surgery," *id.* (App. M, 45a), he did not, as Dr. Meyers claims, "withdraw almost all his criticisms." *Id.* at 9. In fact, two other outside

consultants, one of whom Riverside retained after the conclusions of the first reviewer were questioned and the other of whom was retained by another hospital where Dr. Meyers had privileges, reviewed the same records and came to similar conclusions. "[T]he pattern as a whole raises serious concerns. . . . What comes through as a strong impression is that of a surgeon pushing the envelope . . . accumulating complications in the process." App. D-1.[6]

> The charts . . . reflect significant adverse (and costly) outcomes to the care of a number of patients in a short period of time (three months). Many of the outcomes may have been averted by a more judicious selection of the surgeries for the patients or less aggressive intervention in the operating room. These outcomes . . . suggest significant concerns in the management of the

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[6] Dr. Meyers introduced this reviewer's report as Exhibit 65 to his Brief Opposing Defendants' Craving Oyer.

> patients reviewed and for other potential surgical patients of [Dr. Meyers].

App. E-1.[7]

Among other conclusions, the investigative subcommittee declared,

> [Dr. Meyers'] clinical behavior of aggressive case selection and intra-operative decision-making leads him to proceed when others may take a more conservative approach. This has led to intra-operative misadventures and potentially avoidable complications.
>
> Because of a pattern of this behavior, several prior reviews before the [MEC], and the present action, the committee believes this behavior will not change and will ultimately place patients at an unacceptably high risk.

App. F-1.[8] The investigative committee added that it could not recommend another proctorship because it

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[7] Riverside introduced this report in its Motion Craving Oyer after Dr. Meyers described the report but did not

believed the previous proctorship had not changed Dr. Meyers' practice. *Id.* F-2. The committee made no recommendation to the MEC with respect to the disposition of Dr. Meyers' privileges.

The MEC convened to deliberate over a recommendation to Riverside's Board of Directors. At the meeting, the chairperson of the OB-GYN Department at Riverside, Karen Bruder, M.D., volunteered that if Dr. Meyers were to perform a laparoscopy on her, she would want to be awake so that she could tell Dr. Meyers when to stop the procedure. Although Dr. Bruder explained almost a year later that the MEC misinterpreted her comment, she never has denied the declaration,

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attach it as an exhibit to his *Third Amended Motion for Judgment.*

[8] Dr. Meyers introduced the investigative committee's report into the record as Exhibit 66 to his Brief Opposing Defendants' Motion Craving Oyer.

which is consistent with others' observations that Dr. Meyers' "pushes the envelope" and fails to make "judicious selection" of surgeries.

As Riverside's Bylaws allow, Dr. Meyers pursued several appeals. First he appealed the MEC's recommendation and was afforded a hearing before a hearing officer and a panel of five physicians. The hearing panel made several significant findings, most of which Dr. Meyers fails to disclose:

- the MEC and its investigative committee "acted reasonably and in good faith in the handling of the investigation and revocation of clinical privileges of Dr. Meyers."
- Dr. Meyers should have terminated the surgery leading to his first proctorship when he became aware that he could not measure fluid balances.

- Dr. Meyers fails to dictate operative reports promptly after surgery.

The hearing panel recommended that Dr. Meyers' privileges be restored subject to a second proctorship.

Contrary to Dr. Meyers' claim that the MEC still insisted that Dr. Meyers' "clinical judgment was impaired," *Petition* at 11, the MEC actually voted to *reverse* [its] original recommendation for revocation" and made no finding at that time that Dr. Meyers' judgment was impaired. *See* App. G-1 (emphasis added).[9] Unwilling to undergo a second proctorship, Dr. Meyers appealed to Riverside's Board of Directors the MEC's recommendation of another proctorship.

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[9] See supra n.1. In answers to requests for admission, Dr. Meyers admitted receipt of the MEC's post-hearing recommendation, which is attached as Appendix E.

Riverside's Board of Visitors appointed an Appeals Panel to examine two issues identified by Dr. Meyers: (1) whether the MEC acted reasonably and in good faith; and (2) whether Dr. Meyers should be subjected to a second proctorship. The Appeals Panel concluded, "[T]he history of the matters involving Dr. Meyers were such that the investigating committees found, as they should have, that Dr. Meyers' judgment was questionable." That panel concurred that a proctorship was proper, as a result of which Dr. Meyers was informed of the terms of a second proctorship.

At the end of the process, after Dr. Meyers had completed a proctorship and injured five patients over the next three months, Riverside still restored his privileges subject to a proctorship.

At one time Dr. Meyers declared that he had "nothing to fear from any proctorship." *Third Amended Motion for Judgment* ¶ 155. Several years after Riverside set the terms of proctorship, Dr. Meyers contended that Riverside imposed stringent proctorship conditions. *Id.* ¶ 258. Last year—six years since Riverside imposed the second proctorship—Dr. Meyers conjured a new excuse for failing to complete the proctorship: "it would be unethical for me to inflict on patients an abdominal incision just so I could complete proctorship of my abdominal cases." *See* App. H-1.[10] After his re-instatement at Riverside subject to a proctorship, Dr. Meyers never completed the proctorship.

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[10] This assertion entered the record after the Virginia Supreme Court denied Dr. Meyers' *Petition for Appeal*.

At the end of six years of litigation, Dr. Meyers has faced one dismissal after another as cases against another hospital, another hospital's attorney, two outside reviewers, physicians and hospital administrators have been dismissed. This appeal and an appeal against an outside reviewer, John Partridge, M.D., which also is before this Court on a *Writ for Petition for Certiorari,* are the only cases still standing.

REASONS FOR DENYING THE PETITION

I. THE CIRCUITS UNIFORMLY AGREE THAT, AS A THRESHOLD ISSUE, THE COURT ALONE DECIDES WHETHER A PLAINTIFF HAS REBUTTED THE PRESUMPTION OF REASONABLENESS OF PEER REVIEW ACTION.

Without exception, every federal circuit court addressing whether a professional review action

satisfies HCQIA declares that the *court* may decide this threshold issue before trial. *See Singh v. Blue Cross/Blue Shield of Mass., Inc.,* 308 F.3d 25, 36 (1st Cir. 2002); ("[R[easonableness determinations under the HCQIA may often become legal determinations appropriate for resolution by the judge at summary judgment."); *Brader v. Allegheny Gen. Hosp.*, 167 F. 3d 832, 839 (3d Cir. 1999) ("[T]he real issue is the sufficiency of the basis of the [hospital's] actions."); *Gabaldini v. Washington Cty. Hosp.*, 250 F.3d 255, 260 (4th Cir. 2001) (citing *Brader*); *Meyers v. Columbia/HCA Healthcare Care*, 341F.3d 461, 468 (6th Cir. 2003) (plaintiff has burden on summary judgment of proving that review process was unreasonable); *Sugarbaker v. SSM Health Care,* 190 F.3d 905, 912 (8th Cir. 1999) (quoting *Brader*); *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992)

(quoting House Report's comment that HCQIA "allow[s] court to make a determination that the defendant has or has not met the standards specified in section 11112(a)"); *Brown v. Family Pract. Asoc.*. 101 F.3d 1324, 1334 n.9) (10th Cir. 1996) ("[T]he proper inquiry for the court is whether [the physician] has provided sufficient evidence to permit a jury to find that she has overcome . . . any of the four statutory elements . . . ."); *Bryan v. James E. Holmes Reg. Med. Ctr.*, 33 F.3d 1318, 1332 (11th Cir. 1994) ("HCQIA immunity is a question of law for the court to decide and may be resolved whenever the record in a particular case becomes sufficiently developed.").

In that regard, every circuit applies the same test devised by the Ninth Circuit in *Austin v. McNamara:* "Might a reasonable jury, viewing the

facts in the best light for [the physician], conclude that he has shown by a preponderance of the evidence that the defendants' actions are outside the scope of 11112(a)?" 979 F.2d at 734 (9th Cir. 1992) (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 254 (1986)). This uniformity among the circuits flows from congressional intent: "The Committee intends that these provisions [will] allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible. The provisions w[ill] allow a court to make a determination that the defendant has or has not met the standards specified in section [11112(a)]." *Id.* (quoting H.R. Rep. 903, 99th Cong., 2d Sess. 12, *reprinted in* 1986 Code Cong. & Admin. News 6394).

For all practical purposes, the purported split among the circuit courts—as claimed by Dr.

Meyers—is much ado about nothing. The only sources of the alleged split are the First Circuit's decision in *Singh v. Blue Cross/Blue Shield* and the Eleventh Circuit's ruling in *Bryan v. James E. Holmes Regional Medical Center*. Both decisions address the roles of the judge and jury in HCQIA cases, and both adopt the test first articulated in *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992): "[M]ight a reasonable jury, viewing the facts in the best light for [the physician], conclude that he has shown . . . that the defendants' actions are outside the scope of 11112(a)?" *Singh*, 308 F.3d at 32; *Bryan*, 33 F.3d at 1333. The only perceived difference is whether a jury may decide the ultimate question: has a defendant met the four requirements for immunity to apply?

In *Singh,* the First Circuit unequivocally rejected the physician's suggestion that the statutory presumption of immunity denies him his Seventh Amendment right to a jury trial. *Singh,* 308 F.3d at 32. The court declared, "Given the objective standards set forth in the statute, reasonableness determinations under the HCQIA may often become legal determinations appropriate for resolution by the judge at summary judgment." *Id.* at 36. The First Circuit then declared that no reasonable jury could find that Blue Cross had failed to satisfy the HCQIA standards, and it affirmed the district court's entry of summary judgment. *Id.* at 48.

Likewise, in *Bryan v. James E. Holmes Medical Center,* the Eleventh Circuit declared that HCQIA immunity "is a question of law for the court to decide and may be resolved whenever the record

in a particular case becomes sufficiently developed." *Bryan*, 33 F.3d at 1332. Examining the record, the court reversed a jury verdict favoring a physician and declared that the district court should have granted the hospital's motion for judgment as a matter of law under Rule 50(b). *Id.* at 1337.

The Eleventh Circuit, however, did not vitiate the jury's function. The court declared that if disputed issues of fact exist about a subsidiary issue, including whether the hospital did not satisfy any of the four requirements for HCQIA immunity to attach, the court may submit that issue to the jury. *Id.* at 1333. The Eleventh Circuit merely observed that the ultimate issue of immunity is a legal question reserved to the court. *Id.*

Citing almost every other Circuit, *including* the Eleventh Circuit in *Bryan*, the First Circuit

noted in *Singh*, "[T]he statutory scheme contemplates a role for the jury, in an appropriate case, in deciding whether a defendant is entitled to HCQIA immunity." *Singh,* 308 F.3d at 33-34. In a single footnote, the First Circuit observed that *Bryan* contains an "internal inconsistency": on one hand, the Eleventh Circuit describes an instance in which a jury may decide whether a hospital has met a requirement for immunity; on the other, the Eleventh Circuit ruled that the court alone decides the ultimate question of immunity. *Id.* at 34 n.7. The First Circuit merely declined to adopt the Eleventh Circuit's declaration that the court alone determines the ultimate question of immunity. *Id.*

Upon closer scrutiny of its ruling, including its describing a jury's involvement in the issue of whether a physician was given adequate notice of

the charges and an opportunity to be heard, the Eleventh Circuit might have realized that it was describing one of the four requirements for immunity. *See* 42 U.S.C. § 11112(a)(3). A jury's determination of that "subsidiary issue of fact" effectively would dictate the ultimate issue of whether the defendant enjoys immunity under HQCIA. The Eleventh Circuit would recognize this "internal inconsistency" and, instead of declaring that the ultimate question of immunity rests with the judge, would note that, for all intents and purposes, a jury's role in deciding a factual issue could dictate whether a defendant enjoys immunity. That acknowledgment would not unite any division between any circuits but merely would clarify the respective roles of the judge and the jury. By no means would clarification of any purported division

alter the outcome in this case because, like many courts before it that faced the same issue, this trial court ruled as a matter of law that Riverside's peer review action was reasonable.

II. THE TRIAL COURT APPLIED THE STATUTORY STANDARD OF OBJECTIVE REASONABLENESS AND NOT ANY "DEFERENTIAL STANDARD."

Dr. Meyers asserts that Riverside urged the trial court to defer to the judgment of the peer reviewers and to ignore his allegations in his myriad amendments. Whatever Riverside encouraged the court to do does not dictate what the court actually did. In any event, Dr. Meyers is *wrong*: Riverside implored the trial court to examine the allegations and to apply HCQIA's presumption of immunity but not to substitute the trial court's personal vision of a reasonable peer action from the perspective of the

actual peer reviewers. *Petition for Writ* (App. J at 33a). This request flowed from directly congressional intent and common law: "Under [HCQIA], the Court's role 'is not to substitute [its] judgment for that of the hospital's governing board or to reweigh the evidence regarding the renewal or termination of medical staff privileges.'" *Bryan v. James E. Holmes Reg. Med. Ctr.*, 33 F.3d 1318 (11th Cir. 1994), *cert. den.*, 514 U.S. 1019 (1995).

Dr. Meyers contends that the trial court ignored HCQIA's standard of objective reasonableness and, instead, applied a standard of judicial deference. Considering that the trial court granted Dr. Meyers leave to amend his action three times, with each amendment amplifying the facts surrounding Dr. Meyers' suspension, this Court will be hard-pressed to conclude that the trial court

shrugged off Dr. Meyers' assertion that the peer review action must be objectively reasonable. Moreover, the trial court's successive rulings, which mention nothing of judicial deference, clearly rebut Dr. Meyers' argument:

> I find from the exhibits and arguments of counsel that the standards for professional review actions have been fulfilled. The standards necessary for protection have not been rebutted by a preponderance of the evidence.

Petition for Writ (App. F at 16a ¶ 1).

> The Court granted the Plaintiff's oral motion to file a written motion to reconsider the ruling . . . that the Defendants' actions complied with the statutory standards under [HCQIA] and that the Plaintiff had failed to rebut the Defendants' presumption of immunity . . . .

Id. (App. C, 7a ¶ 1). The record clearly demonstrates that the trial court did not give

Riverside a pass but, instead, examined the allegations and the hundreds of exhibits that became a part of the record and concluded that Dr. Meyers had not rebutted the presumption that Riverside's action was reasonable.

Dr. Meyers also misstates the trial court's purported reliance on Virginia common law. Nowhere in the court's letter opinions and orders does the trial judge cite the opinions identified by Dr. Meyers, nor does the court remark that judicial deference carries the day.

In fact, the cases cited by Dr. Meyers relate a physician's seeking injunctive relief for the refusal of a hospital to grant privileges or for a hospital's suspension of privileges—

not to a physician's seeking damages for the suspension or revocation of those privileges. *See Medical Ctr. Hosp. v. Terzis*, 235 Va. 443, 367 S.E.2d 728 (1988) (reversing trial court's injunction against hospital's suspension of doctor's privileges); *Khoury v. Community Mem. Hosp.,* 203 Va. 236, 123 S.E.2d 533 (1962) (declaring that trial court lacks authority to enjoin hospital's refusal to grant privileges). Although these cases do reflect the courts' reluctance to interfere with a hospital's internal affairs, they declare nothing about courts' power to provide financial redress. Consequently, Dr. Meyers misstates that the trial court simply deferred to the judgment of the peer review participants.

III. THE TRIAL COURT APPLIED THE CORRECT STANDARD WHEN AWARDING ATTORNEY'S FEES AND COSTS, AND THAT AWARD IS SUBJECT TO AN ABUSE OF DISCRETION.

HCQIA not only encourages frank peer review through reviewers' immunity from damages but also discourages unreasonable challenges to peer review through the reviewers' recovery of attorney's fees:

> [T]o the extent that a defendant has met the standards set forth under section 1111(a) . . . and the defendant substantially prevails, the court shall . . . award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

42 U.S.C. § 11113; *see Addis v. Holy Cross Health Care Sys. Corp.*, 88 F.3d 482, 485 (7th Cir. 1996)

(noting § 11113's "fee-shifting provision designed to deter plaintiffs from filing meritless lawsuits"). Court consistently review a trial court's award or denial of attorney's fees in HCQIA cases for abuse of discretion. *See, e.g., Johnson v. Nyack Hosp.*, 964 F.2d 116, 123 (2d Cir. 1992); *Muzquiz v. W.A. Foote Mem. Hosp.*, 70 F.3d 422, 431 (6th Cir. 1995); *Addis v. Holy Cross Health Care Sys. Corp.*, 88 F.3d 482, 486-87 (7th Cir. 1996); *Sugarbaker v. SSM Health Care*, 187 F.3d 853, 857 (8th Cir. 1999); *Smith v. Ricks*, 31 F.3d 1478, 1487 (9th Cir. 1994).

In this case the record speaks volumes, with the three amendments to the original action composing merely a small stanza. Before Dr. Meyers even filed the original action, Riverside had offered to re-instate his privileges subject to a proctorship, and within four months after he filed suit Dr.

Meyers had entered into a proctorship agreement. Dr. Meyers was not content: he filed suit against Riverside, another corporate medical provider,[11] and five peer review participants and over the next five years propounded hundreds of requests for admissions, interrogatories and requests for production of documents.

Riverside produced thousands of pages of patient charts and peer review records. Riverside and the individual defendants also answered numerous rounds of discovery. Riverside defended the depositions of all the co-defendants and approximately 25 other participants in the peer review process, including hospital administrators, doctors and nurses. Convinced that Riverside was

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[11] Dr. Meyers later agreed that the claims against another corporate co-defendant, Urology of Virginia, Inc., should be dismissed with prejudice from the case.

out to get him, Dr. Meyers even deposed the plaintiff in a malpractice action that had not been pursued, the woman who had suffered a heart attack on the operating table. He failed to extract from her any evidence that Riverside had encouraged her to file suit. In fact, that suit named Riverside *as a co-defendant.*

The absurdity did not end with discovery. After the trial court dismissed claims for implied breach of contract and conspiracy and as he faced a *Motion for Summary Judgment* based on a more expansive depiction of the peer review process than he had portrayed, Dr. Meyers sought permission to file a *Third Amended Motion for Judgment.* Over Riverside's strong objection, the court indulged Dr. Meyers again. Ironically, this pleading expanded the court's view of a reasonable peer review process.

Facing another motion to dismiss, Dr. Meyers filed a *Motion for Reconsideration,* which failed to re-examine the law but, instead, raised new allegations of fact and injected more documents into the record. Those documents that Dr. Meyers described but failed to include as exhibits Riverside itself put into the record over Dr. Meyers' objection.

After years of reading pleadings and amendments, the trial court determined properly that the peer review action was reasonable:

> . . . I have reviewed the many briefs filed, the cases cited and the 100 exhibits filed with plaintiff's Motion for Reconsideration.
>
> I have previously found, and again today find, from the pleadings, exhibits, briefs, records of other cases,[12] and after

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[12] The "records of other cases" refers to the other actions filed by Dr. Meyers, all of which have been dismissed, and to other cases sharing similar legal issues, the factual underpinnings of which were explored to show their similarity with this case.

> reviewing plaintiff's Motion for Reconsideration, his brief supporting the Motion for Reconsideration with the attached 100 exhibits, that the process and standards for professional review of the defendant Hospital under [HCQIA] were reasonable . . . ."

Petition for Writ (App. B, 4a ¶¶ 2,3). Without ruling on whether Dr. Meyers' action was unreasonable, the court noted that the parties would brief or have a hearing on Riverside's previously filed motion for attorney's fees and costs. *Id.* (App. B, 5a ¶ 5).

Not only did the parties brief their positions regarding the reasonableness of Dr. Meyers' action in the filing of and pursuit of litigation, but they also presented oral argument on their respective positions. Having considered the record,[13] the Court awarded Riverside its attorney's fees and costs from

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[13] Dr. Meyers quotes from the transcript of the hearing beginning at page 86. *See Petition for Writ* (App. D, 11a)

April 10, 2003, through April 20, 2006. That span coincides with the Court's granting Dr. Meyers leave to file a *Second Amended Motion for Judgment* at a hearing on April 9, 2003, and its hearing oral argument on various motions on April 20, 2006, including Riverside's *Motion for Reconsideration of Demurrer,* which hearing led to the court's dismissal of the case.

The record belies Dr. Meyers' positions about the court's findings of the parties' reasonableness in the peer review process and in the litigation. Examining the voluminous record, the court denied Riverside over $120,000 in attorney's fees and costs incurred before the hearing on April 9, 2003, when the court finally stopped giving Dr. Meyers the benefit of the doubt, and after April 20, 2006, when Riverside faced Dr. Meyers' improvidently filed

Motion for Reconsideration. And contrary to Dr. Meyers' assertion, the court made a legal finding that the peer review process was reasonable, *see id.* (App. B, 4a ¶¶ 3-4), and then an independent factual finding that no person involved in the peer review process made any knowingly false statement. *Id.* (App. B, 5a ¶ 1). Because HCQIA immunizes from damages all persons in the peer review process if the action was reasonable, the court was not required to examine the allegations of knowing falsehoods. *See* 42 U.S.C. § 11111(a)(1).

Having done so, however, the court "further [found] no evidence" of any person's knowingly providing false information. *Id.* (App. B, 4a ¶ 4 - 5a ¶ 1). HCQIA excludes immunity to those persons who provide "knowingly false" information—not those who acted recklessly—but only if the process

itself was unreasonable. *See id.* § 11111(a)(1), -(a)(2). Consequently, even a finding of recklessness would not satisfy a requirement of Dr. Meyers' proving "knowing falsehood." Consequently, not only did the trial court properly conclude that the process was reasonable and that the participants are immune but it also entertained Dr. Meyers' assertion that any person knowingly made a false statement even when the first conclusion mooted the second issue.

On one point Dr. Meyers is correct: like any case involving medical peer review, the facts of this case differ from the next. Its factual differences, however, do not create a case of first impression. A case of first impression presents an unanswered legal question. *See California v. Federal Energy Reg. Comm'n*, 495 U.S. 490, 497 (1990). Dr. Meyers

would have this Court declare that his allegations, if true, render the peer review action unreasonable. He misses the mark:

> HCQIA's objective reasonableness standard is a perfectly valid guide for peer review bodies. The "reasonable belief" standard embodies the discretion that health care professionals have traditionally exercised in determining whether or not their peers meet a requisite level of professional competence. [Citation omitted.] Courts respect this discretion because "any attempt to catalog every medical practice that would fall into the prohibited category would result in the sort of encyclopedic and unwieldy statute [already] rejected as unnecessary." [Citation omitted.]

Freilich v. Upper Chesapeake Health, Inc., 313 F.3d 205, 212-13 (4th Cir. 2002).

Courts consistently have affirmed adverse actions against suspended physicians even if those

physicians actually did not harm anyone or the ultimate determination of whether a physician should have been suspended demonstrates that the precautionary action was unwarranted. *See, e.g., Singh v. Blue Cross/Blue Shield of Mass.*, 308 F. 3d 25, 41 (1st Cir. 2002) (reversal of committee's recommendation does not indicate that initial adverse recommendation was made without reasonable belief that recommendation would further quality heath care."); *Patel v. Midland Mem. Hosp.*, 298 F.3d 333, 339 (5th Cir. 2002) (physician rebutting reports supporting suspension fails to rebut reasonableness of medical executive committee); *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 913 (8th Cir. 1999) (physician showing that bases for precautionary suspension were unjustified fails to rebut presumption that participants had

reasonable belief that suspension would further quality health care); *Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026, 1030 (4th Cir. 1994) (physician's proof that reviewers lacked understanding fails to contradict existence of reasonable belief that participants were furthering health care quality); *Austin v. McNamara*, 979 F.2d 728, 735 (9th Cir. 1992) (hearing panel's finding that revocation was unreasonable does not overcome presumption that defendants acted in reasonable belief that suspension was warranted).

Consequently, in a case involving two summary suspensions in 15 months, a failed proctorship, injury to five patients after the first proctorship, and the concurrence of three outside reviewers that some of Dr. Meyers patient charts reveal poor clinical judgment (incident to and after

the initial recommendation)—to say nothing of the protracted litigation leading to dismissal—Dr. Meyers has failed to demonstrate that the trial court abused its discretion when awarding Riverside less than half of the attorney's fees it incurred.

CONCLUSION

Stripped of any purported split over the role of judge and jury in HCQIA cases, this appeal lacks any compelling reason this Court should grant a *Writ*. Devoid of any evidence that the trial court abdicated its responsibility to examine the peer review action objectively, this appeal loses any basis for this Court independently to examine the record below. And considering the trial court's firsthand observations not only of Dr. Meyers' pleadings but also of his course of conduct through several years of litigation, this Court cannot say that Dr. Meyers has

shown any abuse of discretion in awarding Riverside a portion of its attorney's fees and costs. Because the record provides no path leading to a compelling federal question and amounts to no more than Dr. Meyers' challenge to the trial court's findings, this Court should deny his *Petition for Writ of Certiorari.*

Respectfully submitted by

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Counsel for the Respondents

APPENDIX

* * *

There is no mention of the outflow volume. At 11:20 a.m., the patient had a spontaneous cardiovascular arrest. At that time, 14,950cc of 1.5% glycine had been used, 7700cc had been collected in the suction canisters, and urine output was recorded at 2500cc. Consequently, there was a fluid deficit of approximately 5000cc at the time that the patient experienced a cardiovascular arrest. Prompt cardiopulmonary resuscitation ensued, additional IV Lasix, and hypertonic saline was administered, and to everyone's good fortune, the patient apparently recovered with no permanent neurologic sequelae.

This case is disturbing for a number of reasons. There appears to be inadequate nursing notes to document appropriate fluid management. If the nurse was keeping a running count of fluid volume used for distention as compared to the volume of fluid obtained in the suction canisters, there is no record of this. There is no documentation of regular communication with the surgeon in the nursing notes until 10:50 a.m., a full one and a half hours after the start of the surgical procedure. By then, there already existed a 3000cc deficit.

The physician was either unconcerned or ignored the potential complications associated with intravascular intravasation of fluids during operative hysteroscopy. A lack of clinical electrolyte determination, administering Lasix and, apparently, being informed by the circulating nurse that the fluid deficit was increasing. The physician should have been aware that commonly used liquid distention media (i.e. glycine 1.5%) can result in significant hyponatremia and hypo-osmolality. Review of the medical literature suggests that seizures, permanent brain damage, and death can occur with serum sodium levels of 116mmol/L.

* * *

Under no circumstances should an operative hysteroscopic resection of a uterine fibroid extend beyond an hour and 30 minutes. Ideally, these surgeries should be limited to less than 60 minutes.

* * *

Jay M. Cooper, M.D.

Appendix A-2

Riverside Regional Medical Center
Panel Hearing

IN RE: Paul J. Meyers, M.D.

Day VII

Date: May 23, 2001

DR. SMITH: Back to Ms. Artis, you mentioned earlier that you do take some responsibility for her situation. Would you say that you exhibited impaired intraoperative clinical judgment on her?

THE WITNESS: I think I miscalculated, and I think that -- and I think I made a mistake. I think we all have. Everybody has 10 or 15 minutes in their lives that they'd rather relive.

Page 178, lines 15-2

Appendix B-1

VIRGINIA:

IN THE CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS

BRANDI M. PENNY, Plaintiff,

v. Case No. 31614W-01

PAUL J. MEYERS, M.D.
106 Flag Creek Road
Yorktown, Virginia 23693

and

RIVERSIDE HOSPITAL, INC.
SERVE:
Richard J. Pearce
Registered Agent
606 Denbigh Boulevard
Suite 601
Newport News, Virginia 23608 Defendants.

MOTION FOR JUDGMENT

COMES NOW Plaintiff, BRANDI M. PENNY ("Penny"), by counsel, and for her Motion for Judgment against Defendants PAUL J. MEYERS, M.D. ('Meyers") and RIVERSIDE HOSPITAL, INC. ("Riverside"), states the following:

Parties

1. Penny is a resident of the Commonwealth of Virginia who reasonably relied upon Defendants to perform services on her behalf. Upon reasonable information and belief, Defendants failed to properly perform those services and Penny sustained permanent injuries as a result.
2. Defendant Meyers is believed to be a physician practicing the medical business of obstetrics and gynecology in the City of Newport News, Virginia. Beginning in 1993, and at all material times hereto, Penny and Meyers had a patient-physician relationship, continuously and without interruption through February 2000. At all material times hereto, Meyers was also an employee, principal, or other agent of Defendants Riverside and all of his actions were

performed within the scope of his employment or agency with Riverside.

3. Defendant Riverside is a Virginia corporation, d/b/a Riverside Regional Medical Center ("RRMC"). Riverside maintains its registered office in the City of Newport News. At all material times hereto, Defendant Riverside employed Defendant Meyers to carry out its business, and Defendant Riverside is vicariously responsible for his actions.

4. Defendant Riverside also negligently granted and maintained employment and staff privileges for Defendant Meyers, for which actions it is directly liable to Penny.

Virginia Physicians for Women

September 25, 2000

Thomas T. Thames, II, M.D.
Vice President Medical Affairs
Bon Secours Hampton Roads
150 Kingsley Lane
Norfolk, Virginia 23505

Re: Review of cases of Dr. Paul Meyers
PRELIMINARY FINDINGS AND REPORT

Dear Dr. Thames:

Attached are summaries of my critiques of each of the files you forwarded.

You will note that in none of the cases did I find glaring or consistent deviation from Standard of Care or basic principles of sound practice.

Yet the pattern as a whole raises some serious concerns. In some of the files, the charting is faulty with conflicting information or operative notes long overdue. In other cases, selection of procedural technique and approach is tenuous. And the cluster of adverse events, especially bowel injuries, is far higher than expected even for a surgeon in the learning curve of laparoscopic skills.

What comes through as a strong impression is that of a surgeon pushing the envelop of what can done laparoscopically and accumulating complications in

the process. While some of the injuries occur with Dr. Meyers' non-laparoscopic cases, these seem fewer, more random, and more understandable.

Please feel free to contact me to discuss this review in more detail.

Sincerely,

John R. Partridge, M.D., F.A.C.O.G.

Appendix D-2

Excerpt of Report of Jordan G. Pritzker, M.D.
December 26, 2000

The charts reviewed of the practices of Dr. Meyers reflect significant adverse (and costly) outcomes to the care of a number of the patients in a short period of time (three months). Many of the outcomes may have been averted by a more judicious selection of the surgeries for the patients or less aggressive intervention in the operating room. These outcomes, as documented in the hospital charts, suggest significant concerns in the management of the patients reviewed and for other potential surgical patients of the doctor reviewed. Earlier intra-operative consultation may have averted some (or allowed for a 'shared' responsibility) of the outcomes of the patients. The rationalization for the procedures performed and the ensuing outcomes may be better substantiated by the specific patient office charts of Dr. Meyers.

The threshold for which to restrict or suspend a doctor's practice based on the outcomes of patients of certain procedures is subjective, particularly when the career of a colleague is "on the line." The outcomes of the patients herein reviewed suggest that, in the least, possible pre-operative review and surgical supervision of this doctor may be of benefit to the quality of care of the patients in the community.

Excerpt from:

Investigative Committee Report
Paul Meyers, M.D.
July 15, 2000
Page 3.

Dr. Meyers practice patterns will not change therefore, the frequency of complications will not change.

The committee based its finding on the fact that Dr. Meyers had recently completed a 3 month period of proctorship following a similar peer review investigation in December 1999. It was the conclusion of the 1999 review that he demonstrated significantly impaired clinical judgment in the preoperative, intra-operative and postoperative management of four patients under his care at the time.

Following the resumption of his laparoscopic privileges in October 1999, he was noted again to have experienced an increased number of complications in a short period of time.

The committee currently finds that there remains a similar pattern of behavior as note during the 1999 Investigation. His clinical behavior of aggressive case selection and intra-operative decision-making

leads him to proceed when others may take a more conservative approach. This has led to several intra-operative misadventures and potentially avoidable complications.

Because of a pattern of this behavior, several prior reviews before the medical executive committee, and the present action, the committee believes this behavior will not change and will ultimately place patients at an unacceptably high risk.

Riverside Regional Medical Center

June 8, 2001

Paul Meyers MD
106 Flag Creek Road
Yorktown, VA 23693

Dear Dr. Meyers:

I am informing you that the Medical Executive Committee met on Wednesday, June 6, 2001 to review the report and recommendations of the hearing panel that was selected pursuant to the adverse peer review recommendation of the MEC on July 25, 2000. I am aware that Mr. Tom Carpenter, the hearing officer forwarded a copy of their report to you via certified mail on Tuesday, June 5, 2001.

The Medical Executive Committee has voted to reverse their original recommendation for revocation of staff appointment and all clinical privileges. They also voted to accept the hearing panel's recommendations with the following modifications as listed below:

1. Request that the Departmental Chair for Obstetrics/Gynecology at Riverside Regional Medical Center appoint a three (3) person task force to develop the criteria for proctorship. This would include the departmental chair, a member from the department appointed by him and a member from the department recommended by you. The task force will work in conjunction with

the Director of Surgical Services and the Vice President of Medical Affairs.

The Medical Executive Committee cannot accept the panel's recommendation that the condition for a remedial course and proctorship be made concurrent wit that of Mary Immaculate Hospital. The granting of privileges is institution specific. To the extent that the timing of the two organizations" processes happen to coincide, that would be fortuitous, but Riverside will go forward with the process described above notwithstanding any process at Mary Immaculate. Please provide information regarding any laparoscopic course(s) that you have undertaken.

The recommendations for the criteria and the scope of the proctorship shall be submitted to the Medical Executive Committee for their review and adoption.

2. The Hearing panel recommended that all operative reports be completed in the time frame established by the Department of Obstetrics/Gynecology and the Department of Medical Records. The requirement and sanctions for medical record compliance is the sole responsibility of the Medical Records committee and the Medical Executive Committee.

3. The Medical Executive Committee will require that you agree to not tape record any conversations or meetings with members of the medical and hospital staff without their consent.

This recommendation with the stipulated modifications will be forwarded immediately to the Board for final action at its meeting on June 27, 2001 because this recommendation is not adverse to you.

Pursuant to the Medical Staff Bylaws, Article XI, Section 1, you have within fourteen (14) days of your receipt of this letter to request an appellate review, if you believe this recommendation is adverse to you. The final Board action would then occur following the appeal process. The request shall be in writing, and shall be delivered to the Chief Executive Officer either in person or by certified mail, and shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within fourteen (14) days as provided, you shall be deemed to have accepted the recommendation involved and it shall thereupon become final and immediately effective."

Until this recommendation has been reviewed and adopted by the Board of Directors, your voluntary agreement to not exercise your clinical privileges remains in place.

Sincerely,

William B. Downey
Executive Vice President/Administrator

CC: Rudolph Freeman Jr., MD
Vice President of Medical Affairs

AFFIDAVIT OF PAUL J. MEYERS, M.D.
Dated December 19, 2007

11. I completed my proctorship of vaginal cases on or about July 2006. I have been proctored for 6 laparoscopic cases. I have not had open abdominal cases to proctor because I do almost all of my gynecological procedures that are suitable to a vaginal or laparoscopic approach and rarely do gynecological procedures through an abdominal incision. I consider that it would be unethical for me to inflict on patients an abdominal incision just so that I could complete proctorship of my abdominal cases. My proficiency or competence to perform gynecological operations abdominally was never questioned or criticized, and none of the actions taken on my privileges were based on abdominal gynecological operations (or vaginal operations for that matter).

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(3)

Supreme Court, U.S.
FILED
OCT 10 2008
OFFICE OF THE CLERK

No. 07-969

In The
Supreme Court of the United States

PAUL J. MEYERS, M.D.,
Petitioner,

v.

RIVERSIDE HOSPITAL, T/A RIVERSIDE REGIONAL MEDICAL CENTER; RUDOLPH FREEMAN, JR., M.D.; RICHARD HOEFER, M.D.; CHARLES FAULK, M.D.; BRUCE KAUDER, M.D.; AND PAUL REIN, M.D.
Respondents.

On Petition for Writ of Certiorari to the Supreme Court of Virginia

PETITIONER'S REPLY BRIEF

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I. MANY AVERMENTS IN RESPONDENT'S STATEMENT OF FACTS ARE IRRELEVANT, MISLEADING OR UNTRUE.

Events that occurred after July 25, 2000, the date on which the MEC recommended revoking all of Meyers' privileges, Br. in Op. at 10, 14-19, have no relevance to the reasonableness of that action or of Riverside's investigation. *See Singh v. Blue Cross / Blue Shield of Massachusetts, Inc.*, 308 F.3d 25, 32 (1st Cir.) (citing H.R. Rep. No. 99-903 at 10 *reprinted in* 1986 U.S.C.C.A.N. 6384, 6393) (reasonableness of peer review action judged by what was know when action was taken). The two expert reports excerpted at Appendix D1-E1, for example, were obtained five or more months after the MEC's recommendation to revoke Meyers' privileges, and were not presented to any peer review committee.[1] Appendix H (recently submitted in opposition to a motion for appeal costs) is not before the Court at all.

Nothing related to Meyers' proctorship is relevant to any issue in this petition and the representations about it, Br. in Op. at, 14-18, are inaccurate and

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[1] Riverside and Mary Immaculate Hospital (MIH) swapped expert reports in February, 2001. Riverside obtained Pritzker's report through a commercial broker, doctorquality.com, after learning of Levinson's reprimand by the California State Medical Board. A different covering letter, dated October 9, 2000, and not Appendix D1-D2, was provided to MIH peer review committees and to Riverside.

misleading. App. 1 at 1a-7a.[2] Equally irrelevant is Brandi Penny's law suit, and reference to it violates a court order incorporating an agreement that Riverside would not use the settlement in its litigation with Meyers. App. 2 at 8a-11a.

Riverside's averments about the Penny case, which Riverside's own expert opined involved no malpractice, App. 4 at 16a, are highly misleading.[3] A member of the ad hoc committee (AHC) that investigated Meyers following the March, 2000 suspension performed the temporary colostomy and had no criticisms of Meyers at the time the complication occurred. App. 5 at 23a.[4]

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[2] Meyers purported contradictions about proctorships, Br. in Op. at 18, are illusory because the cited paragraphs, 155 & 258, refer to different proctorships. Although Riverside ostensibly imposed the second proctorship because Meyers had not operated for 15 months, the MEC is still insisting that Meyers be proctored notwithstanding that he had been operating for several years at another hospital. App. 1 at 1a, ¶ 2 .

[3] The perforation did not occur until after surgery and was promptly recognized. App. 3 at 12a, ¶ 4. Levinson had no specific criticisms of this case, and was critical of the surgeon who performed the colostomy. App. 4 at 14a-16a. Meyers only settled the case because he lost his medical malpractice insurance after Riverside's insurer declared bankruptcy and Riverside refused to defend him. Meyers has had no other settlements or judgments in 16 years of treating mostly indigent patients with complex surgical problems. App. 3 at 12a, ¶ 2.

[4] Riverside defended Dr. Barry Gross, M.D., an Ob-Gyn and Vice President in charge of Riverside Physician's Associates, against a suit by a patient he sent home with a hole in her rectum and who developed near fatal septicemia. Third Am. Mot. for J. at ¶ 26-28.

The averments purporting to rebut statements germane to Meyers' claim that Riverside did not conduct a reasonable investigation are all untrue or rebut a straw man.[5] It is not true that the AHC reviewed any documents related to peer review actions in 1995, Br. in Op. at 11. App. 7 at 28a-29a. These were not even peer review actions. *See* 42 U.S.C. § 11151(9).[6]

This case was not even reviewed, illustrating that Riverside's actions are governed not by outcomes and their causes, but by the person involved. (Gross lost a jury verdict).

[5] Meyers never claimed that the AHC "relied exclusively on the report of an external reviewer", meaning that it relied on nothing else. Br. in Op. at 11. Meyers contended that the AHC relied exclusively on Levinson's report for its information about the cases on which Meyers' suspension was based, Pet. at 9, ¶ 2, and which is true, App. 6 at 24a-25a.

[6] They were letters reprimanding Meyers for ostensibly exceeding the scope of his privileges by performing laparoscopic appendectomies and repairing a suburethral diverticulum. The former hinged on the definition of "incidental", the latter was completely untrue. App. 8 at 30a. The AHC was informed of these actions by Defendant Freeman, Vice President of Medical Affairs, during a presentation he made to the committee about Meyers. App. 9 at 31a-32a. Freeman knew these 'actions' involved only credentialing issues, *id.* at 31a, but he misrepresented them as having involved quality of care concerns, App. 7 at 27a. (This was one of a number of false, defamatory statements that were made, contrary to the trial court's finding on which Riverside relies in part to vindicate the award of attorney's fees, Br. in Op. at 40-41, with knowledge of falsity and not reckless disregard of the truth.)

Riverside's claim that Levinson did not withdraw most of his criticisms, Br. in Op. at 11, is also untrue. Levinson withdrew his criticisms outright in four cases, Pet. at 45a; App. 4 at 17a, 18a, 21a; conceded that his critical statements about two other cases were not true, *id.* at 18a (p237), 20a (p253); and revised his criticisms in two more cases to "mildly" or not "overly" critical, *id.* at 18a, 21a, and conceded that his mild criticism of one of these cases was based on his personal preference, which was at variance with that of most gynecologists, *id.* at 19a.

Riverside's contention that two other reviewers agreed with Levinson, Br. in Op. at 11, is untrue. Partridge and Levinson criticized different cases and agreed in their criticisms of only two cases, App. 10 at 34a-35a (one of which they criticized for different reasons).[7]

The AHC did interview Meyers, Br. in Op. at 11, and Meyers did not claim otherwise, Pet. at 9, ¶ 2, but the committee's failure to question Meyers about the cases on which the 2000 suspension was based, App.

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[7] Partridge stated in his October 9, 2000 letter

> I did not see any indication that Dr. Meyers should not have privileges to perform open laparotomy cases...vulvar cases, cervical cases, and procedures on the vaginal wall such as colporrhaphies.

Pritzker lauded Meyers' removal of large uteruses vaginally as "admirable". These reports further undermine the reasonableness of the MEC's recommendation to revoke Meyers' non-endoscopic privileges.

7 at 28a, or the cases on which his 1999 suspension/proctorship were based, *Id.*, is further evidence that its investigation was unreasonable because no meaningful information was sought at the interview.

II. THE SPLIT AMONG THE CIRCUITS IS MATERIAL AND SHOULD BE RESOLVED.

Riverside's "threshold issue", Br. in Op. at 19-28, concerns what it means to say that summary judgment "is a question of law for the court to decide whenever the record is sufficiently developed". *See e.g. Meyer v. Sunrise Hosp.*, 22 P.3d 1142, 1149 (Nev. 2001) (citation omitted). This or equivalent language means that the court determines whether the requirements for summary judgment contained in the forum's procedural law have been met. *See Manzetti v. Mercy Hosp. of Pittsburgh*, 776 A.2d 938, 944-46 (2001). This determination, like the construction of any statute, is a question of law. *Id.* at 944. But what the court determines is whether there are any *genuine* disputes about *material* facts,[8] and if there are not, whether the substantive law entitles the moving party to a judgment based on the undisputed facts. *See e.g.* Fed. R. Civ. P. 56(c). The trial court does decide as part of this determination what is reasonable within the meaning of § 11112(a) - or at least, whether it does or not, is the question Meyers is asking this Court to decide.

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[8] The substantive law determines what facts are material and what disputes are genuine. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

Who decides what is reasonable under§ 11112(a) decides what facts, and inferences from facts, are material, *Anderson*, 477 U.S. at 248, which in turn affects the evidence a physician may present to defeat the presumption of immunity. This is not "much ado about nothing". Br. in Op. at 23. Nor is the split among the circuits semantic.

Under Eleventh Circuit law, the trial court decides what is reasonable under § 11112(a), and, hence, what disputes over facts and inferences are material; juries decide only "subsidiary issues". *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1333-34 (11th Cir. 1994), *cert. denied* 514 U.S. 1019 (1995). For example, had Riverside disputed whether the AHC reviewed any medical records, the jury would be permitted to resolve the dispute, but not whether failure to review medical records is reasonable within the meaning of § 11112(a)(2); the court would decide that question. Before any subsidiary issue would be submitted to a jury, the court will have already decided what is reasonable with respect to that issue, otherwise it could not know whether the dispute was material, and hence needed to be resolved by a jury.

By contrast, under First Circuit law,

> "[t]his jury involvement is not limited to disputes over subsidiary issues of fact. Rather, a jury could be asked to decide the ultimate issues of reasonableness set forth in the immunity statute".

See Singh, 308 F.3d at 34 (footnote omitted). This is a very different standard under which *genuine* disputes

over the reasonableness of peer review actions are jury questions. If reasonable minds could differ on whether Riverside's investigation was reasonable, the jury would decide whether it was or not. *Id.* at 36. Riverside's contention that the two standards are the same because Dr. Singh made invalid arguments to the First Circuit and could not create a *genuine* dispute over the reasonableness of Blue Cross's action, Br. in Op. at 24-25, is a non-sequitur.

III. THE TRIAL COURT DID NOT APPLY THE CORRECT STANDARD OF REVIEW.

Riverside has acknowledged that it urged the trial court to defer to its peer reviewers, and that the correct standard under 42 U.S.C. § 11112(a) is not deferential. Rep. at 28. The evidence it cites to prove that the court nonetheless applied the correct, objective reasonableness standard, does not support the proposition for which Riverside cited it.[9]

Riverside also explains that by deference it was merely "implor[ing] the trial court...not to substitute [its] view of a reasonable peer review action from the perspective of the actual peer reviewers" (sic), and that this request "flowed from congressional intent and common law". Br. in Op. at 28-29. But congressional

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[9] Riverside cited the following: that the court permitted Meyers "to amend his action three times" (actually twice: the original complaint was nonsuited); that the court "examined the allegations and hundreds of exhibits that became part of the record"; and that whatever it "encouraged the court to do does not dictate what the court actually did". Br. in Op. at 28-31.

intent regarding deference is nowhere to be found in the language of HCQIA, and *Bryan* cannot be read to be creating federal common law to effect the purposes of HCQIA. Pet. at 22-23. It is also difficult to believe that this is what Riverside really meant by deference given that the court told the parties, "I think they did everything reasonably". Pet. at 51a.

That Riverside "implored the court to examine the allegations and to apply HCQIA's presumption of immunity", Rep. at 28, does not demonstrate that the court applied the correct standard to grant what amounts to summary judgment. Pet. at 13, n.8.[10] On the contrary, the fact that Riverside has consistently focused the courts' attention only on its own perspectives on its actions, and has never rebutted a single material fact or evidence Meyers has presented, proves that it urged the court to apply an incorrect, not a correct standard of review. *See Anderson*, 477 U.S. at 255 (court must accept non-movant's evidence unless rebutted). As its Statement of the Case ('Statement") demonstrates, these accounts have contained very little of relevance to the sufficiency of Meyers evidence, and have never, for example claimed

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[10] Virginia law disfavors summary judgment, *see Slone v. General Motors Corp.*, 457 S.E.2d 51, 52 (Va.1995) (citation omitted), and the presumption has no effect on that standard, or the quantum of evidence required to defeat summary judgment. *Singh*, 308 F.3d at 32-33. The presumption only relieved Riverside of its initial burden to produce evidence to support its contention "that there is no genuine issue of material fact on its compliance with the HCQIA standards". *See id* at 33.

- that it is not true that the documents on which the AHC relied contained fabrications, contrived criticisms, or false or misleading statements about Meyers or his cases;
- that the AHC did review medical records;
- that Levinson was not provided with incomplete medical records;
- that Bruder did not inform Freeman that there were many problems with Levinson's report;
- that Freeman did not refuse Bruder's request to review the medical records that had been sent to Freeman;
- that the AHC relied for information about Meyers' complication rates on invalid and inaccurate statements contained in an external reviewer's report (Cooper's);
- that Riverside's peer review actions never involved obstetrical or non-endoscopic cases.[11]

The legal relevance of the 1998/9 peer review actions to the present litigation on which Riverside has focused, Br. in Op. at 5-9, derives solely from the fact that Riverside has used the 1999 proctorship to justify the suspension of all of Meyers' privileges in March, 2000.[12] They have no relevance to what happened

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[11] This list does not exhausts Meyers' evidence that Riverside's investigation was unreasonable.

[12] Without these prior actions the five complications would not have justified the March, 2000 suspension. App. 5 at 22a-23a; App. 11 at 37a-38a. Meyers produced evidence to prove that the peer review actions in 1998/9 were unreasonable, and, therefore, that the 2000 suspension was unreasonable: suspension of Meyers' *laparoscopic* privileges was based on *hysteroscopic* case, App. 9 at

thereafter other than by confirming that these prior actions involved only endoscopic cases, they undermine rather than support the reasonableness of the MEC's recommendation to revoke Meyers' non-endoscopic privileges in July, 2000.

Yet, Riverside has made the hysteroscopic case on which Meyers' suspension in 1998 was based, App. 9 at 33a, the lynch-pin of its claim that it is entitled to immunity. Br. in Op. at 5-9. Riverside has recounted this patient's complication with varying color and accuracy to every court in every brief and at every hearing, and has never understood that even if its averments about this case were true, they could not invest it with immunity if its investigation after the March, 2000 suspension or the recommendation to revoke all Meyers' non-endoscopic privileges in July, 2000 were not reasonable under § 11112(a).

But they are not true. Riverside provided Cooper incomplete information about the hysteroscopic case.[13] Cooper was not made aware that the nurses made after the fact entries in the medical records without identifying them as such, Pet. at 53a, ¶ 3, and that the information was provided to Meyers at Meyers' request

---

33a, and only Meyers' laparoscopic cases were proctored; cases were changed to justify suspension of Meyers' laparoscopic privileges, Pet. at 54a; attending physicians in private practice consulted Meyers about complex surgical cases while he was being proctored, App. 12 at 39a; Meyers was denied a hearing on the suspension.

[13] Riverside also provided Cooper with misleading information about Meyers' complication rates. Pet. at 10 n. 5.

after he stopped the procedure to assess the fluid deficit.

Cooper could not have had Meyers' operative report because in it Meyers described that he stopped operating to assess fluid balance, and estimated the fluid deficit to be approximately 1500 ccs. App. 13 at 40a.[14] Meyers may have underestimated the deficit, but he was not unconcerned about it or ignored it, as Cooper incorrectly assumed based on the information he was provided. Br. in Op. at Appendix A-2. Another physician grappling with the same systemic deficiencies six months earlier, estimated the deficit of his patient to be about 3000 milliliters. App. 14 at 41a. It was pure serendipity that Meyers' and not his patient developed bradycardia and asystole because their patients had very similar serum sodium concentrations. Third Am. mot. for J. at ¶ 120.

Because Riverside was more concerned with cost than quality, it did not purchase a closed-circuit fluid balance monitoring device for its facilities. Because it does not practice effective quality oversight, this systemic deficiency, Pet. at 55a, was not corrected after a serious case of fluid overload occurred six months before Meyers' hysteroscopic complication. The latent condition within the system , Pet. at 61a, ¶ 2,

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[14] Cooper also did not realize that the operative part of the procedure lasted only about one hour twenty minutes, not two hours, Br. in Op. at Appendix A-2, because Meyers first performed a diagnostic hysteroscopy to confirm the prior findings. (This was not Meyers' patient; the residents asked him to perform the procedure because it was technically difficult).

that caused the complication lay dormant waiting to entrap some unfortunate physician and his or her patients.

That physician happened to be Meyers. The career of an outstanding teacher and surgeon[15] has been destroyed, and federal law used to protect the actions that destroyed it. This case, and the questions it presents, evidence a compelling need for this Court to speak authoritatively on how trial judges, who will likely be interpreting HCQIA for the first time, should examine the record and decide what is reasonable within the meaning of this statute.

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[15] Even a member of the committee that investigated Meyers in 1998, acknowledged that Meyers "had very good technical ability [and]....was a good surgeon." App. 15 at 42a.

CONCLUSION

The writ of certiorari should be granted.

Respectfully submitted

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APPENDIX

APPENDIX 1

AFFIDAVIT OF PAUL J. MEYERS, M.D. (Dated Dec. 19, 2007)

Having been duly sworn, I, Paul J. Meyers, M.D., state the following:

* * *

2. The primary hospital where I perform most of my deliveries and surgery is Sentara-Careplex Hospital ("Careplex") in Hampton (formerly called Sentara Hampton General Hospital). I was originally granted privileges only in Obstetrics as a result of Riverside's action on my privileges. I was granted privileges to perform open gynecologic, vaginal procedures, and laparoscopic tubal ligations on or about April 1, 2003; to perform laparoscopic procedures on or about January 1, 2004. I was reappointed to the medical staff of the Careplex with full privileges on or about January 1, 2005. On or about January 1, 2006, I was appointed Director of Women's Health at the Careplex and I represent the Ob-Gyn department on the Careplex Hospital's Peer Review Committee.

3. I described the events surrounding the proctorship of my gynecological surgical cases at Riverside in an affidavit I executed on June 6, 2005, attached hereto as **Exhibit 1.** I affirm and incorporate the statements contained in that affidavit herein.

4. Dr. John Paulson joined the Riverside faculty in or around July 1, 2002. After Riverside refused to approve Dr. Morrison as a proctor, notwithstanding that he had become board certified, Dr. Paulson agreed to proctor my case and was approved as a proctor in May 2005. However, Dr. Paulson left Riverside due to conflict with administration, again leaving me without a proctor.

5. On or about November 1, 2006, I met with Chris Stolle, the Vice President for Medical Affairs, regarding my re-appointment to the Riverside medical staff. * * * I informed Dr. Stolle that I had previously requested that the faculty serve as proctors, and had been declined both by Dr. David Rayl, who was the residency director in 2002, and subsequently by Dr. Jewell Barnett who is still the current director. * * *

* * *

7. On or about February 21, 2007, I received a letter from Riverside, informing me that Riverside had unilaterally altered the conditions of the proctorship, in that it needed to be completed within 90 days from the date of the letter (approximately January 21, 2007). At the time, Dr. Paulson had already submitted a letter resigning his privileges at Riverside, and therefore Riverside knew that I was without a proctor.

8. * * * Dr. John Hyde, is a gynecologic oncologist with extensive experience with level IV laparoscopic procedures who was hired by Virginia Oncology approximately 6 months before Riverside's Ob-Gyn Residency Program was placed on probation. * * * I asked Dr. Hyde to act as my proctor, and he agreed.

9. The Riverside Medical Executive Committee met on or about April 11, 2007, and did not approve any of the suggested proctors, as it claimed that I would not be able to complete the proctorship in time even if it did approve a proctor. In addition, it did not provide an extension to the previously imposed deadline.

* * *

[Exhibit 1]

AFFIDAVIT OF PAUL J. MEYERS, MD.
(Dated June 6, 2005)

* * *

3.

In my efforts to secure a proctor for endoscopic cases, I first contacted Dr. David Bersinger, then Chairman of the Department of Obstetrics and Gynecology. He was unable to act as a proctor himself but recommended that I ask the OB/GYN teaching faculty at RRMC if they were willing to act in that capacity. * * *

4.

Pursuant to Dr. Bersinger's suggestion, I contacted Dr. David Rayl, then Residency Director of the Department of OB/GYN at RRMC, and asked if he and/or any members of the teaching faculty would be willing to act as my proctors and offered in exchange to give lectures to the residents as I had done over

many years while I was a member of the full time teaching faculty. * * *

Dr. Rayl informed me that he and his faculty neither had the time nor the expertise to act as my proctors. * * *

6.

I next contacted the Chairmen of all academic departments in the state of Virginia, to solicit their assistance to no avail. * * *

7.

Finally, I asked if Drs. Douglas Thom and Timothy O'Connell, who are partners of my wife, if they would be willing to act as my proctors. Riverside agreed to permit them to act in this capacity and they signed an agreement on March 14, 2002.

8.

During the period of February through March, 2002, I interviewed for and received a letter of intent for a position as a staff obstetrician gynecologist at the Peninsula Institute for Community Health ("PICH"). PICH is a non profit organization receiving federal grant money to provide medical services to indigent patients in federally designated underserved areas of Newport News and Hampton. The credentialing process for that position took another six months, and I was not able to see patients at PICH until I was credentialed both at PICH and Sentara Hampton

General Hospital ("SHGH"), sometime in the middle of September 2002.

9.

The majority of patients at PICH are uninsured. Those that have insurance are insured through the Medicaid program. In Virginia Medicaid is administered through private HMOs. The vast majority of PICH Medicaid patients belong to the Sentara HMO and are required to receive care within the Sentara system. Only a small fraction of PICH patients have the Medicaid HMO – Healthkeepers – that is accepted at RRMC.

10.

In addition, Riverside has a standing policy of requiring uninsured patients to pay 80% of their estimated costs in advance. *See* **Ex. 5.** Representative charges for a vaginal hysterectomy, abdominal hysterectomy and laparoscopy at Riverside all exceed $8500. *See* **Ex 6**.

11.

Few if any uninsured PICH patients are able to have elective surgery at RRMC. Therefore, only a very small fraction of my patients can realistically have surgery at RRMC.

12.

In November and December 2003, shortly after I was in a position to admit any patients to RRMC, Drs.

Thom and O'Connell both declined to continue acting as my proctors. I have discussed the reasons for this change of heart personally with both Drs. Thom and O'Connell. Contrary to what RRMC has represented to another judicial officer in another forum that I attended, the unwillingness of Drs. Thom and O'Connell to continue to act as my proctors had nothing to do with quality of care issue connected with me or my surgery or my cases.

13.

At the end of December 2003, I met with Drs. Freeman and Barnett at RRMC's request to discuss my proctorship situation. Several proctors were discussed at that time, one of them, Dr. Jeffrey Morrison. The only objection raised was that he was not yet board certified and also was not a full time member of the RRMC medical staff. Dr. Morrison recently became board certified, and is now a member of the RRMC full time medical staff. Nonetheless, I was notified by Dr. Freeman that Dr. James Mullins, new Chairman of OB/GYN at RRMC, refused to approve Dr. Morrison as my proctor ostensibly because he would not be willing to tell me when to stop. Ex. 7

14.

During the entire period, 1998-2000, that my laparoscopic cases were investigated, I was never informed as to what specific laparoscopic operation I should have abandoned. I was merely informed that in the opinion of some obstetrician-gynecologists at Riverside I should not have attempted to perform laparoscopic surgery in less than five cases because in

their opinion the circumstances presented contraindications to laparoscopic surgery. These circumstances were:

(1) a uterus weighing 1100 grams;

(2) a patient who had a pelvic abscess;

(3) a patient who required several procedures to correct recurrent prolapse that lasted about 8 hours but who had an otherwise uneventful procedure sustained no complications;

(4) on patient who was admitted with subacute bowel obstruction on the medical service, and whose diagnosis was uncertain.

15.

Since the medical literature does not, to my knowledge, indicate that any of these situations are contraindications to laparoscopic surgery, and I am aware of several articles indicating that these types of cases are managed laparoscopically at other centers, I disagree with my colleagues. None of my critics have ever provided me with any medical literature to support their opinions, and, therefore, they have not persuaded me of the correctness of their opinions.

* * *

APPENDIX 2

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. CL 02-31614W-01

[Dated April 21, 2006]

BRANDI M. PENNY,
Plaintiff,

v.

PAUL J. MEYERS, M.D. and RIVERSIDE HOSPITAL, INC.,
Defendants.

ORDER

This matter came before the Court on the Motion of the Plaintiff ("Penny") to dismiss with prejudice her action against the Defendants in this matter, and on the Motion of Defendant Paul J. Meyers ("Dr. Meyers") to incorporate by reference herein the terms of the Release executed by the parties, and to file said Release under seal.

It appearing to the Court from the endorsement of all parties to the action that no opposition exists to the

relief requested by Penny or requested by Dr. Meyers, it is hereby:

ADJUDGED, ORDERED, and DECREED that the terms of the Release executed by the parties are incorporated into this Order. It is further:

ADJUDGED, ORDERED, and DECREED that the Release executed by the parties will be filed under seal and shall be opened only pursuant to the written agreement of Dr. Meyers and Riverside Hospital, Inc., or further order of the Court. It is further:

ADJUDGED, ORDERED, and DECREED that the action is dismissed with prejudice.

The Clerk is directed to provide a certified copy of this Order to all counsel of record following entry.

THIS CAUSE IS ENDED.

ENTER: April 21, 2006

/s/
Judge

I ASK FOR THIS:

/s/
Lewis T. Stoneburner
Wallace B. Wason, Jr.
Cantor Arkema
Post Office Box 561
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(804) 644-1400
Counsel for Plaintiff

/s/
Carlyle R. Wimbish, III
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801 East Main Street, Suite 1800
Post Office Box 1998
Richmond, Virginia 23218-1998
(804) 648-1636
(804) 783-2926 -- Facsimile
Counsel for Dr. Meyers

WITNESS the following signature and seal this 21st day of December, 2005.

/s/
Brandi M. Penny

STATE OF VIRGINIA,
City/County of Richmond, to wit,

This day came Brandi M. Penny, whose name is signed to the foregoing writing bearing the date of the 21st day December, 2005, and has this day acknowledged the same before me in the jurisdiction aforesaid.

Given under my hand this 21st day of December, 2005.

My commission expires: 9/30/2006

/s/
Notary Public

LIMITED RELEASE AS BETWEEN DR. MEYERS AND RIVERSIDE

In furtherance of this Release, and in addition to the foregoing terms, the undersigned further agree, promise and covenant as follows:

1) The parties agree to not disclose or use the settlement in currently pending litigation commenced by Dr. Meyers against Riverside, namely, Newport News Circuit Court, Law No. 31394-EH. The parties understand and agree that this Release does not preclude reporting to the National Practitioner Data Bank or disclosure otherwise provided by law or regulation.

* * *

APPENDIX 3

July 6, 2000

To: Whom It May Concern
Re: Review of records
Paul J. Meyers, M.D.

The following is based on a review of 31 cases seen by Paul J. Meyers from 11/12/99 through 3/1/00.

This group of patients appears to have more pathology than an average group of patients. They appear at higher risk than patients seen in an average gynecologic practice do. This group is compatible with patients referred to a teaching center with complex problems.

The complications in this group are recognized complications of surgery. The risk of complications in patients with complex problems is higher than that in average patients. The risk of complications at laparoscopy is highest for complex surgery, intermediate for sterilization and least for diagnostic laparoscopy. However the risk would be greater at laparotomy than laparoscopy. The risks do not outweigh the potential benefits in Dr. Meyers' patients.

The post-operative care of these patients was diligent and appropriate. The complications were promptly recognized and treated.

Overall, Dr. Meyers appears to have acted reasonably in planning procedures, performing surgery and managing the patients post-operatively.

Sincerely yours,

/s/
Dan C. Martin, M.D.

APPENDIX 4

DEPOSITION OF CARL J. LEVINSON
May 19, 2003

* * *

[p.165]

* * *

Q. So am I right in thinking your criticism is mostly of the second surgery where you believe it should have just been drained?

A. Yes. Well, I do have some criticism of the first one in that there was a complication. * * *

* * *

Q. You're not saying that the first laparoscopic surgery was unindicated, are you?

A. No, it was indicated.

Q. You're not saying it shouldn't have been done laparoscopically, are you?

A. No.

Q. You're not saying that what was done shouldn't have been done, are you?

A. No.

[p.166]

Q. So the complication that resulted from what was done, are you saying he must have done something wrong to have had that complication or - - I'm not quite sure.

A. No, but you are parsing each individual case.
* * *

* * *

[p.167]

Q. So you're critical of the second operation?

A. Very.

Q. Very critical. * * * Are you saying that - - * * * that if you just reviewed this one case, you wouldn't have any criticism, but given that there were these other cases, you were wondering - -

A. Exactly.

Q. - - whether this guy was up to it.

A. Exactly right.

Q. Am I correct about that?

A. Yes.

* * *

[p. 168]

* * *

A. If you had given me this case alone, separate and distinct from any knowledge between this and another case, I would have said that's a known injury with laparoscopy.

* * *

[p. 169]

A. * * * If I had been asked to review this case as a malpractice case, I would have said, "No."

Q. "No" what?

A. No, there's - -

Q. No deviation from standard?

A. - - there's not malpractice.

* * *

[p. 170]

* * *

Q. * * * you were wondering whether he was not biting off more than he could chew because there were all these other complications?

A. (Nodding in the affirmative.)

* * *

[p. 214]

* * *

Q. * * * If that's true, would you have any criticisms of Dr. Meyers if he had a report from an ultrasonographer showing, quote, left ovary is enlarged - -

A. No, I would have no objection on the basis of that other generated ultrasound.

* * *

[p. 230]

* * *

Q. And had you known that that was a postoperative value, presumably you would have not made the criticisms that you made; am I correct about that?

A. That's correct.

Q. And even less would you have made your criticism if you had known that this patient came into the hospital on the 27th of December complaining of acute onset of abdominal pain. Correct?

A. I would have no objection to an immediate laparoscopy.

* * *

[p.237]

* * *

Q. Uh-huh. What else does it say?

A. "It was also noted that the left adnexa and uterus had been previously removed."

Q. So it's not actually true that they didn't describe it, is it?

A. It's tucked away in there.

* * *

[p.238]

* * *

Q. So if the doctor had given the description you have read for us into the record and had taken a picture of the cyst and put it in the medical record, you wouldn't be critical of him, would you?

A. Well, a 4-centimeter simple cyst is not pathology.

Q. So you would be critical?

A. I would be mildly critical.

Q. Let me ask you this: Supposing you laparoscoped a patient because of pain and you found a simple cyst, would you just leave that cyst alone?

A. Probably.

Q. You would?

A. I would.

Q. And is that what the majority of your peers do in a 37-year-old woman?

A. Probably not. I tend to be on the slightly conservative side.

* * *

[p. 240]

* * *

Q. * * * - - I just want you to summarize your criticism for me.

A. I don't know whether there was a preoperative medical clearance on this patient. It struck me that she should have had one.

Q. Do you say that in your report here?

[p. 241]

A. Yes.

Q. Where?

A. She had certain risk factors.

Q. Where does it say she should have had a pre-op clearance, but didn't have one?

A. I shouldn't have to say that.

Q. Oh, okay. That's a criticism you're making now?

A. If she has risk factors, then something should have been done about that.

Q. So you're making that criticism now?

A. Yes.

* * *

[p.253]

Q. Tell me what organ was struck to create a hematoma in the anterior abdominal wall, Doctor.

A. I made a wrong assumption as to where it was and how it was developed.

* * *

[p.288]

* * *

Q. But it's fair to say you're not overly critical of this case?

A. No.

MR. HARRIS: That's correct? Is that correct?

THE WITNESS: That's correct.

* * *

[p.295]

* * *

Q. * * * But if that were true, would you fault him for removing the appendix?

A. In the absence of an abscess and covered by antibiotics, no - -

* * *

APPENDIX 5

Deposition of ERIC M. BASHKOFF, M.D.
June 8, 2005
1:25 p.m.

* * *

[p.8]

* * *

A. Dr. Freeman spent a lot of time defining what the problem was because, at least I can speak for myself, I wasn't aware of all the things that had happened before with the previous peer reviews and evaluations, and so forth. I wasn't privy to any of that information before our meetings.

Q. Okay.

A. So Dr. Freeman, I remember him spending a good deal of time just trying to lay out the groundwork for the case. * * *

[p.119]

* * *

Q. Would I be correct in characterizing your opinion then, that the whole is greater than the sum of its parts?

A. Yes --

MR. HARRIS: That's been asked and answered.

THE WITNESS: - - absolutely. I think that is a very fair statement, Gestalt, which is why I think it's useless to pick at each individual case and try to turn over each individual case and try to justify its legitimacy in one sense or another. You know, the fact that while one case was okay on patient selection, but wasn't okay on complications, one case had a different - - if you take each case individually, sure. The Brandy Penny case, that didn't bother me. I wouldn't have made any conclusion that the, you know, any action should have

[p.120]

been taken against Dr. Meyers based upon my knowledge of that one case but - -

* * *

THE WITNESS: What I'm saying is that it's the sum total of all of the information that we were presented, that yes, it does have an impact greater than the sum of its parts.

* * *

APPENDIX 6

[p.13]

* * *

STEWART WETCHLER, M.D.,
called as a witness, having been first duly sworn,
was examined and testified as follows:

* * *

[p.129]

* * *

DR. SMITH: * * * Is that questionable judgment regarding case selection based on the experience of other - - let's say based on the consensus of the other gynecologists?

THE WITNESS: No. I mean, that was exactly why we deferred to the expert. I think you understand that we used what we know combined with the expert's report because it can only be evaluated by someone who does all the same procedures. And since I do not and the other people on the committee did not, that's why we deferred to the experts. So just because Dr. Meyers does a procedure through the laparoscope that other people in the

[p.130]

department don't do, does not make it wrong. That's why we have to - - and my memories of the literature, though I did not do a specific search for this, were that you couldn't find an objective standard to go by. That's why we deferred to an expert.

* * * And we knew that we didn't know, and we knew that we didn't feel capable of evaluating the procedures ourselves and we were not given the full charts to look through, didn't look through the full charts that I recall. But we knew we needed someone who did the procedures to evaluate it.

DR. SMITH: Would you summarize this by saying that your criticism of Dr. Meyers' case selection is based solely on the Levinson report?

THE WITNESS: Primarily. * * *

* * *

[p.139]

DR. SENEY: I think so.

HEARING OFFICER CARPENTER: Dr. Wetchler, I have one question and this kind of follows up on Dr. Seney's question. If I go out and I get 15 Ob-Gyns who do surgery, am I likely to see a divergence in opinions in that group of 15 Ob-Gyns on how much is too much in laparoscopic work?

THE WITNESS: Absolutely.

HEARING OFFICER CARPENTER: And given those same 15 Ob-Gyns, is it also likely that I would be more likely to have people favor laparoscopy in sort of direct proportion to their ability with the instrument? In that same group of 15, if we had a laparoscopic ace and we had somebody - -

THE WITNESS: Absolutely, that's possible. * * *

HEARING OFFICER CARPENTER: Thank you, Doctor.

DR. KADAR: Two questions. You said that you wanted Levinson to evaluate this because you wanted

[p.140]

somebody who was doing these procedures. Are you making the assumption that Levinson does laparoscopic resetion of rectal endometriosis, prolapse surgery? Do you know that for a fact?

THE WITNESS: I don't know that for a fact.

* * *

APPENDIX 7

Deposition of:
STEVEN E. MARKS
October 28, 2005
9:33 a.m.

* * *

[p.81]

* * *

BY DR. KADAR:

Q. All right. Prior to the 1999 action, * * * - - it's your understanding there was a prior investigation into quality of care issues; is that correct?

A. That was my understanding.

Q. Do you recall reviewing a report on that investigation?

A. I don't recall.

Q. And if there is no report from those prior years whenever they were listed in Exhibit A of your report, then you wouldn't have reviewed it; is that correct?

A. I believe that's correct.

* * *

[p.112]

* * *

Q. And also you didn't actually question him about any specific cases, did you?

MR. HARRIS: You mean that he personally or the Committee?

DR. KADAR: Either.

THE WITNESS: No, I don't believe so.

[p.113]

BY DR. KADAR:

Q. * * * Doctor, you didn't question him either about the 1998 cases, 1998-1999 cases?

A. No, we did not.

Q. And you didn't inquire about the nature of the investigations in '95?

A. No, we didn't ask him about any specific cases in 1995.

Q. Not only specific cases, but you didn't ask him about the nature of those investigations, did you?

A. No, we did not.

* * *

APPENDIX 8

EXAMINATION UNDER TRIAL of THOMAS L. HANNA, M.D., held on January 20, 2005

* * *

[p.79]

* * *

Q. And repair of a suburethral diverticulum, would Dr. Meyers be allowed to perform that procedure?

A. Yes.

* * *

APPENDIX 9

The deposition of RUDOLPH FREEMAN, M.D., a Witness, commencing on October 27, 2005

* * *

[p.8]

* * *

Q. Okay. And F-6 is a history of the corrective actions. The same thing, you would have drafted that, did you?

A. Correct.

[p.9]

Q. And you did an overhead presentation?

A. That would probably be the same context, same time frame as that, so the answer would be yes.

* * *

[p.15]

* * *

Q. You weren't actually involved in the prior credentialing issues that came up in '95 and '96 with Dr. Meyers, were you?

A. I would have almost certainly been involved in the '96 incident only because I would have been the vice president of the medical staff that year. * * *

* * *

[p.18]

* * *

Q. But doctor, you summarized for the ad hoc committee there were actions in April of '95 and June of 1995.

A. And that's just a matter of looking at the credentials file. * * *

Q. * * * - - my question is quite simply, is that the actions that took place in 1995 and 1996 were credentialing issues.

A. That's correct.

* * *

[p.19]

* * *

Q. Okay. That was my question. So you knew there were no complications involved?

MR. HARRIS : Objection to the form.

THE WITNESS: I was not aware of any other matters other than credentialing matters in 1995 and 1996.

* * *

[p.72]

* * *

THE WITNESS: It is my recollection that the suspension was based on the complications that occurred to Ms. Artis.

* * *

[p.73]

* * *

Now, just for the record, Sabrina Artis was a hysteroscopic case, correct?

A. Correct.

* * *

APPENDIX 10

MEMORANDUM

TO: MEDICAL STAFF CREDENTIALS COMMITTEE
FROM: JAMES M. MULLINS III, M.D., CHAIR, OB/GYN
DATE: 3/4/01
RE: PAUL MEYERS, M.D.

* * *

It is apparent from a review of Dr. Meyers' laparoscopic case log, in which he notes participation in 664 laparoscopic procedures, that he has a breadth of experience. His overall complication rate of 1.9% is lower than most published complication rates. Even his complication rate of 8.5% (447 cases) from 1999-4/1/2000, during which 67% of his cases were "major" or "advanced" laparoscopic procedures, is consistent with previously published rates, and not significantly different from the laparoscopic complication rate of 4% at Mary Immaculate Hospital in 1999.

A review of the evaluations by Drs. Partridge and Levinson, * * * serve only to demonstrate that there may be several different approaches to the same gynecologic problem(s). Drs. Partridge and Levinson,

however, agreed in the criticism of two laparoscopic procedures, * * *

APPENDIX 11

The discovery deposition of PAUL REIN, M.D., commencing on December 15, 2005

* * *

[p.8]

* * *

Q. * * * Talking about rates, whether it be transfusion rates, infection rates, complication rates, would you agree with me that rates fluctuate in the short term?

A. Absolutely.

* * *

[p.10]

* * *

Q. * * * Would you agree with me that, I'll phrase it one way and if it's not clear, you let me know, that random events can cluster?

MR. HARRIS: Objection to the form. Go ahead.

BY DR. KADAR:

Q. Do you understand my question?

A. Sure. Of course, of course they can cluster.

* * *

[p.23]

* * *

Q. * * * Would you agree with me that the complication rates of a procedure varies with the complexity of the operation?

A. I would agree with that.

Q. Would you agree with me that for a given operation, the complication varies depending on the difficulty of the case?

* * *

THE WITNESS: I agree with that.

* * *

[p.31]

* * *

THE WITNESS: That couldn't be more incorrect. No one is ever suspended over five cases. No one is ever suspended over five cases. * * *

[p.32]

* * *

BY DR. KADAR:

Q. So you agree with me that just because you have a run of five bowel complications in itself would not warrant summary suspension of a physician, correct?

* * *

THE WITNESS: It is terribly unfair on your part to pull five cases out of context. You have to look at the big picture.

* * *

APPENDIX 12

OB/GYN CHAIRMAN'S REPORT
PROCTORSHIP, PAUL MEYERS, M.D.
PROCTOR: WILLIAM J. MANN, M.D.
October 6, 1999

* * *

Summary

* * *

Dr. Mann * * * also noted that several attending physicians requested Dr. Meyers opinion as to the endoscopic management of specific private patients.

* * *

* * * Of the cases reviewed, six other attending physicians had asked him to assist with difficult procedures.

* * * I believe Dr. Meyers has uniformly fulfilled the terms of his proctorship. He is recognized within our own community as a skilled and competent surgeon.
* * *

Karen L. Bruder, M.D., FACOG
Chairman, Department of OB/GYN
Riverside Regional Medical Center

APPENDIX 13

OPERATIVE REPORT

PATIENT: * * * AGE: * * * MR#:
PHYSICIAN: * * * LOC: * * * DATE: 12/10/98

PAGE 2

PROCEDURE: * * * This had been accomplished by 10:50 a.m. At the time input and output was assessed; 9000 in and ~~50 to 100~~ 5300-plus out ~~and~~ in suction, ~~of~~ and 850 in the Foley. The fluid in the kick bucket on the floor was estimated to be 1500 cc, resulting in a fluid deficit of approximately 1500 cc. At that time the patient was hemodynamically stable, without evidence of pulmonary edema, hemodynamic or cardiac destabilization. * * *

APPENDIX 14

OPERATIVE REPORT

PATIENT: * * *	AGE: 48	MR#: 23-00-73
PHYSICIAN: * * *	LOC: DIS	DATE: 03/31/98

* * *

PROCEDURE: * * * We were unable to account completely for 3,000 cc of irrigation fluid. It was undoubtable that a good 1-2 liters of this were spilled on the floor and on the drapes, and on my gown. * * *

APPENDIX 15

Deposition of:
CHARLES FALK, M. D.
October 28, 2005

* * *

[p.77]

* * *

BY DR. KADAR:

Q. Now, do you have an opinion now of * * * of Dr. Meyers' technical ability as a surgeon? Do you have an opinion?

A. I always thought that Dr. Meyers had very good technical ability. I thought he was a good surgeon.

* * *